United States v. State of Texas

Monitoring Team Report

Denton State Supported Living Center
September 27-October 1, 2010

Date of Report: November 19, 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 (State Centers) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement, effective June 26, 2009. The Settlement Agreement covers 12 State Supported Living Centers, including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the ICF/MR component of Rio Grande State Center. In addition to the Settlement Agreement (SA), the parties detailed their expectations with regard to the provision of health care supports in the Health Care Guidelines (HCG).

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

Initial reviews conducted between January and May, 2010, were considered baseline reviews. Compliance reviews begun in July, 2010, are intended to inform the parties of the Facilities' status of compliance with the SA. This report provides the results of a compliance review of Denton State Supported Living Center (DSSLC).

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.

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

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

(a) **Onsite review** – During the week of September 27-October 1, 2010, the Monitoring Team visited Denton 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 began 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.

IV. Executive Summary

At the outset, the Monitoring Team would like to thank the management team, staff and individuals served at Denton State Supported Living Center (DSSLC) for their welcoming and open approach to this visit. It was clear that the State's leadership staff and attorneys as well as the management team at DSSLC 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. Moreover, the facility made a number of staff members available to the monitoring team in order to facilitate the many activities of the monitoring team, including setting up appointments and meetings, obtaining documents, and answering many questions regarding facility operations. This was much appreciated and made possible an efficient and accurate review.

As a result, a great deal of information was obtained during this tour as evidenced by this lengthy and detailed report. Numerous records were reviewed, observations were conducted, and interviews were held. Specific information regarding numerous individuals is included in this report. It is the hope of the monitoring team that the information and recommendations contained in this report are both credible and helpful to the facility.

Second, the monitoring team found management, clinical and direct care professionals eager to learn and to improve upon what they did each day to support the individuals at DSSLC. Many positive interactions occurred between staff and monitoring team members during the weeklong onsite tour. All monitoring team members had numerous opportunities to provide observations, comments, feedback, and suggestions to managers. It is hoped that some of these ideas and suggestions, as well as those in this report, will assist DSSLC in meeting the many requirements of the Settlement Agreement.

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

Abuse, Neglect and Incident Management

- DSSLC implemented a system of UIR auditing/monitoring. Samples of 10 UIRs were reviewed each month. This audit checks, among other things, timeliness of reporting.
- Rights posters were in place across the Facility.
- DSSLC had a well-organized system for abuse prevention, detection, and reporting and a well-organized and managed system for incident management. The implementation of a video surveillance system in June, 2010, was a significant enhancement that resulted in a substantial increase in reported allegations with investigations confirming significantly more allegations.
- DSSLC had done a good job training its staff about abuse and neglect. The monitoring team was able to validate substantial compliance with this Action Step.
- Compliance with required background checks was confirmed.

Integrated Protection, Services, Treatment and Supports

- The new PSP policy and process had been initiated, staff were being trained, and monitoring of annual PSP meetings was in place.

Integrated Clinical Services

- For persons receiving behavioral supports or interventions, the Facility had a process designed to identify who would benefit from Alternative and Augmentative Communication (AAC) or speech assistance. Attendance at all Positive Behavior Support Committees by a Speech and Language Pathologist (SLP) had begun, and an SLP provided consultations to those individuals identified as having speech or language issues that may be contributing to the target behavior.

At Risk Individuals

- DSSLC was engaged in piloting a new system for assessing risk of individuals living at the facility. DSSLC is to be commended for its initiative in developing a different approach to the risk assessment process. For the most part objective criteria were articulated for each risk factor that would cause an individual to be placed in one of three risk categories: high, medium, or low. The system also allowed for clinical judgment to substitute, if warranted, to strict adherence to the stated criteria.

Psychiatric Care and Services

- DSSLC took positive steps to improve the psychiatry participation with the interdisciplinary process. A psychiatrist now attends Behavior Support Review Committee (BSRC) meetings, and psychiatrists now meet periodically with the on-site neurologist. Psychiatrists started to attend the annual PSP meeting of individuals under their care, and quarterly PMR meetings began to serve as the quarterly updates for the PSP.
- DSSLC implemented use of the comprehensive psychiatric assessments that were detailed in Appendix B of the SA. These assessments were based on a format that required detailed psychiatric diagnoses, based on background information, mental status examination, medical information, and family history, amongst other things.
- The monitoring team confirmed that DSSLC psychiatric services were provided by qualified individuals, and that staffing levels were sufficient. Accordingly, SA provisions J1 and J5 were found to be in substantial compliance.
- The monitoring team examined DSSLC psychiatric assessments and diagnostic formulations. All individuals reviewed had a psychiatric assessment in the clinical record, and many of the evaluations were in the format required by the SA. The monitoring team found that most

evaluations were conducted in a clinically justifiable manner and resulted in clinically justifiable diagnoses. The evaluations often provided specific psychiatric symptoms/behavioral characteristics that could be the basis for monitoring psychotropic medication treatments.

- The monitoring team found good coordination of psychiatry and neurology. Accordingly, SA provision J15 was found to be in substantial compliance.
- The monitoring team found that there were good facility level procedures for monitoring psychotropic polypharmacy. Accordingly, provision J11 was found to be in substantial compliance.

Psychological Services

- In addition to staff with board certification, the Behavioral Services department conducted at the University of North Texas a required behavioral "boot camp" for all Master's and Doctoral staff not formally pursuing board certification. This boot camp consisted of 40 hours of classroom instruction and practical experience in applied behavior analysis.

Medical Care

- Many important steps to improve medical care have been taken, including the recent hire of a new medical director, the pending hire of a physiatrist, establishing a physician to conduct clinical reviews, contracting with a hospitalist, enhancement of the peer review and quality review process, enhancement of the risk assessment tool, and significant improvements with integration of clinical services with the team process.

Nursing

- The Nursing Department had adopted, implemented, and trained the RN Case Managers and other nurses in August, 2010, on the Health Care Protocol for Developmental Disability Nurses to use for developing health care plans. DSSLC had adopted and implemented Guidelines for Comprehensive Nursing Assessment and the accompanying Comprehensive Nursing Assessment Form. All RN Case Managers were trained in the use of the Comprehensive Guidelines by the end of July, 2010. RN Case Managers began using the Comprehensive Nursing Assessment Form in August, 2010.
- The Facility had self-initiated a Pneumonia Work Group to analyze and identify causative factors contributing to incidences of all types of pneumonia with emphasis on aspiration pneumonia, and to develop and implement strategies to minimize the incidents of pneumonia.
- All individuals reviewed were current with immunizations.

Dental Services

- The Facility was in compliance with their ability to provide emergency dental services for individuals in need of emergency dental services during regular hours of operation and for after hours.

Consent

- DSSLC had taken some early initiative to arrange for training for guardians and potential guardians on the roles, responsibilities and expectations of guardians. As a part of the Provider Fair held on 9/10/10, the Facility included a one-hour workshop on guardianship presented by the Assistant Probate Court Investigator for Denton County. This was reported to have included the process for obtaining guardianship, the role of a guardian and the expectations of the court as to the duties and responsibilities of a guardian.

Most Integrated Setting

- Although the Facility reported it was not in compliance with the issuance of the Community Placement Report at required six month intervals, the monitoring team found that the Facility did collect all the required information but had not assimilated it into the required report. The

monitoring team suggested that other documents the Facility had produced could be combined to create the Community Placement Report, and a final document was provided prior to the end of the site visit. Overall, the Facility would appear to be in substantial compliance with this component.

Recordkeeping and General Plan Implementation

- The new recordkeeping policy and record format had been implemented for nearly all individual records. Training had been provided.
- An audit process had been put in place that included identification of deficiencies and a procedure to notify staff of corrective actions needed and to follow up on completion.

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

Restraints

DSSLC continued to struggle with administrative and clinical systems with respect to restraint use. No chemical restraint has been used since the baseline review. Physical restraint had increased significantly.

Documentation issues with the Restraint Checklist, Face-to-Face Assessment/Debriefing were common. The Facility had an internal auditing/monitoring system that identified many of these issues and provided staff with immediate on-the-spot training.

The Facility had not addressed the review requirements associated with individuals experiencing restraint more than 3 times in a rolling 30 day period. A template had been developed to accomplish this and was in the very early stage of implementation.

The Facility's daily review of restraint episodes was primarily administrative in nature and needed to be more clinically oriented.

Staff were current in restraint training and a curriculum review indicated the training presents appropriate content. DSSLC's auditing/monitoring data suggests that improvements in the competency based nature of the training are warranted.

The Facility had a process to audit restraint records and provide on-the-spot training to staff. The Facility's Restraint Reduction Committee had become much more active and meeting content appears to be substantive. Although these were positive steps, much more needs to be done to ensure accurate documentation and to reduce use of restraint.

Abuse, Neglect and Incident Management

There was clearly a problem with timely response from the Department of Family and Protective Services (DFPS) in initiating investigations. Initial investigatory activity often exceeded the 24 hour requirement, sometimes by days.

Quality Assurance

DSSLC had established a Quality Assurance/Quality Improvement Council (the Council). The Council took the place of the Performance Improvement Committee. The first meeting of the Council was on 9/23/10. Information, including data, bar, and line graphs was reviewed for sections C, D, E, F, J, K, M, O, P, Q, and R of the Settlement Agreement. DSSLC also had a Trends Analysis Committee in place. These organizational structures are a good foundation for the future development and refinement of the QA/QI process that is needed to ensure services and supports meet the needs of individuals served and the requirements of this Settlement Agreement.

Integrated Protections, Services, Treatments and Supports
DADS issued new policy direction on PSP development on 7/30/10. DSSLC received training on the new policy in August, 2010. DSSLC began training its staff on 8/23/10. The new PSP format and process was implemented at DSSLC on September 1, 2010. At the time of implementation, and at the time of the monitoring visit, not all staff had received initial training on the new process. The monitoring team had an opportunity to observe a staff training session on 9/29/10 attended primarily by nurses.

The DADS policy is being implemented without the benefit of a DSSLC specific policy. The target date set by the DSSLC for a local policy is 12/1/10.

The monitoring team reviewed all PSPs developed using the new process and attended three PSP meetings during the week of the review. Staff involved in the new process were, for the most part, enthusiastic and embraced the new process as it focuses on the individuals' vision for the future and his/her strengths and aspirations. Meetings were observably more interesting than those attended during the baseline review. As one might expect when a change this significant is initiated, initial implementation will have (and did have) mixed results. Discussion focused on the individual and many attempts were made to draw the individual into the conversation. Staff did their best to follow the new process but the meetings did not flow smoothly. Staff were struggling to adapt to this different way of conducting a PSP meeting. DSSLC had a monitor/reviewer in each meeting who took notes and immediately debriefed the team after the meeting.

Integrated Clinical Services
The monitoring team found encouraging progress. There was effort to develop integrated planning in the PSP meeting, beginning with attendance by clinicians. The inclusion of the Speech and Language Pathologist (SLP) in the PBSC meetings can bring a valuable perspective and improve selection of replacement behaviors.

There was not yet a process to involve the PST in review of recommendations by outside clinicians.

Actual integration of decision-making was still a work in progress. Coaching and monitoring was in place at the PSP meetings to provide opportunities to improve.

Minimum Common Elements of Clinical Care
There were signs of progress on completing scheduled assessments and establishing an interdisciplinary process that may lead to recognition of changes in health and behavioral status that need timely response. Changes in status were not always recognized and reported, discussion awaited scheduled meetings, and there were not thorough assessments when there was decline in function.

Use of clinical indicators for review of progress was variable, which might be one reason why changes in status did not lead to action.

At-Risk Individuals
DSSLC was engaged in trying a new system for assessing risk of individuals living at the facility. This trial began 9/1/10 and had not been in place long enough to produce data for the monitoring team to review. DADS was reviewing a draft new policy on At Risk individuals. This draft incorporated many of the elements DSSLC had developed for its trial. In addition DADS is piloting a related system at Lubbock and plans to roll this out to the other Centers, beginning with DSSLC. DSSLC is to be commended for its initiative in developing a different approach to the risk assessment process and DADS should also be commended for moving forward in piloting a new system.

Although the initial implementation of the pilot developed by the DSSLC was reviewed by the monitoring team and represented a substantial improvement, development of policy and implementation of a system will need to show that it improves the Facility's ability to identify risks and provide appropriate supports to individuals.

Psychiatric Care and Services

DSSLC took many positive steps in the six months since the baseline tour. The facility started to use psychiatric assessments as outlined in Appendix B of the SA, and completed Reiss Screen administrations for all individuals living at DSSLC. DSSLC took positive steps to improve the psychiatry participation with the interdisciplinary process, but further improvement still remained.

PST procedures for discussion and documentation of risks associated with medication treatment were not sufficient.

Psychological services

The Facility had made progress in increasing participation in classes for BCBA preparation, as well as offering a behavioral "boot camp." Despite noted progress, the Facility was not able to demonstrate that PBSPs had been developed by personnel competent in applied behavior analysis.

The Facility presented both internal and external peer review processes. Evidence at the time of the site visit did not demonstrate that the peer review processes were successful in ensuring that PBSPs comported with acceptable practice in applied behavior analysis.

Numerous limitations in data collection procedures were documented during the site visit. The Facility had not implemented a routine procedure for assessing the quality of behavior data. In addition, many reviewed records reflected an inability of the facility to effectively monitor responses to interventions and conduct the necessary modifications to assessment and intervention plans.

Documentation at the Facility reflected that assessments were rarely conducted as frequently as necessary or in a manner that produced meaningful results. No records reviewed included adaptive or intellectual assessments conducted within accepted time frames. Functional assessments often lacked all essential components and typically did not produce specific hypotheses regarding function.

At the time of the site visit, the Facility had identified persons in need of counseling or other non-PBSP services, but no plans had been developed.

Many staff had difficulties in understanding and/or implementing behavior interventions due to the complex language, layout, and organization of the plans. In addition, at the time of the site visit, the Facility did not routinely assess the implementation of PBSPs.

Medical Care

Although many important steps to improve medical care have been taken, much work is still required by the Facility. In particular, the Facility needs to focus more attention on individuals whose functioning and health status are declining to determine the cause of the decline and ways to minimize it.

Subsequent reviews will focus not only on the clinical process but on actual outcomes based on observational assessments of individuals. Of significant issue is the number of deaths noted at the Facility. It was reported that there were 29 deaths at the Facility since October of 2009. When compared with the published mortality rate for people with developmental disabilities who reside at developmental centers of 11.7, Denton's rate was over four times that of the expected norm for developmental centers. The absolute rate may or may not be justified; however, the mortality review process at the Facility did not provide the analysis necessary to address deaths and develop actions to improve health care, let alone to identify and respond to this apparent high mortality rate.

Nursing Care

Some progress had been made with increasing nursing staffing, particularly on the night shift. The Nursing department has room for improvement in documentation, assessment, and notification of physician of acute illness and injuries.

Although the Nursing Department had adopted, implemented, and trained the RN Case Managers on the newly revised Guidelines for Comprehensive Nursing Assessment and accompanying form in August, 2010, not enough opportunities had occurred to demonstrate significant improvement in completing comprehensive nursing assessments for the monitoring team to find compliance.

Although numerous new policies and procedures had been developed, adopted, and implemented since the baseline review, the statewide nursing work group was continuing to develop other policies, procedures, and guidelines to improve nursing practices and to ensure compliance with the Settlement Agreement and Health Care Guidelines. As more policies, procedures, and guidelines are developed and implemented, progressive improvements should be made toward compliance.

Although the Facility is working to reduce pneumonia, there remains much improvement to be made in preventing or control infectious disease process, particularly aspiration pneumonia and sepsis.

Significant progress had been made since the baseline review in an effort to improve medication administration practice and reduce or minimize the incidents of medication errors. However, the Facility did not have adequate space to provide privacy for individuals to receive medication, or freedom from distraction for the nurses which is needed to help reduce the potential for medication error, or facilities accessible for nurses to wash their hands. The Pharmacy's WORx system was problematic in printing the Medication Administration Records (MARs) with adequate information needed to provide the nurses administering medication with the complete instructions for the number of pills to make the prescribed dose and to safely administer medication. The Medication Error System of analyzing and trending medication error data was not easy to understand and needs to be revised so it can be clinically useful.

Pharmacy Services and Safe Medication Practices

Significant effort had been made to enhance pharmacy services. Meaningful review processes had been developed to ensure medication was not dispensed in the event of an interaction or known side effect. However, when pharmacists made recommendations, physicians often reviewed them but took no action and provided no rationale for not acting on the recommendation.

Occasional examples of inappropriately completed physician's orders were identified. Procedures need to be refined to ensure all orders are reviewed by the pharmacist and any issues addressed.

Quarterly Drug Regimen Reviews (QDRRs) were completed timely, but action was not always taken on recommendations by the pharmacists, and justification for not accepting recommendations was not always documented.

Quarterly MOSES and DISCUS reviews were done timely, but more intense monitoring for side effects was not initiated in clinically relevant situations, such as when a new medication was added, an individual's condition worsened, or when abnormal laboratory monitoring was noted. The Facility did not have a process in place that ensured timely identification, reporting and follow up remedial action regarding all significant or unexpected adverse drug reaction

Although the pharmacy had developed a new system to review medication variances identified by the pharmacy, the pharmacy system was not integrated into a process that was responsible for the total oversight of medication variances.

Physical and Nutritional Management

A Physical and Nutritional Management Team (PNMT) has been formed and there are plans to consolidate the Nutritional Management Team (NMT) into the PNMT; however, this had not occurred as of this review. A process that outlines the responsibilities of the team as well as their scope had not yet been developed as the team is less than a month old. There was still no evidence that data is collected and the team is reviewing this data to better identify system issues or respond to recurrent issues on a regular basis.

DADS was in the process of developing a new risk policy and procedure that is planned to address the need to more accurately identify an individual's risk. DSSLC has developed an interim set of criteria for identifying individuals who are at an increased physical and nutritional risk.

Supports regarding the areas of oral care and medication administration were missing from the assessment process and were not included in the PNMP.

PNMPs were not regularly reviewed in the occurrence of a change in status and were not comprehensive due to the plans lacking information regarding oral care and medication administration.

Staff was observed not implementing PNMPs and not displaying safe practices that minimize the risk of PNM decline. Individuals were observed poorly positioned and with safe dining strategies not implemented. Per interview, staff again was not knowledgeable of the plans and why the proposed strategies were relevant to the individuals' well being. There was no process in place to ensure PNM supports for individuals who are determined to be at an increased level of risk were only provided by staff who have received the competency based training specific to the individual.

DSSLC has just recently increased monitoring but there was no evidence that staff or the individual were being monitored in all aspects in which the individual was determined to be at increased risk. There was not a formal process in place that ensures individuals with increased PNM issues are provided with increased monitoring.

All Individuals did not receive an annual assessment that addressed the medical necessity of enteral feeding or potential pathways to oral status. Those individuals who did receive assessments did not have clear justification as to why the tube was necessary nor did the assessments list possible pathways to oral intake.

Physical and Occupational Therapy

Overall, there was an approach that focuses on accommodation rather than prevention of decline in physical status especially as it relates to the occurrence of falls. There was a lack of analysis and investigation regarding root cause of issues. This represents a reactive approach rather than a proactive approach that focuses on prevention.

Assessments were completed in accordance to the schedule set forth by DSSLC; however, assessments were not being consistently completed in response to a change in status. Additionally, the areas related to oral motor, oral hygiene, and medication administration were lacking in detail or were missing from the existing report.

Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills.

When interventions were provided, plans were not implemented as written and staff were not knowledgeable of the OT/PT plans.

A system did not exist that ensures staff responsible for positioning and transferring high risk individuals receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff.

Dental Services

Usually only brief mention of recommendations was commented upon in the PSP but ramifications of oral and dental pathology were not documented, especially for serious cases. Upon cursory review of clinical records at the living area, instances of significant dental issues were not clearly and rationally documented in the personal support plan or addendums to the personal support plans.

Dental records and notes were in the current medical records of those reviewed; however, the records did not adequately explain dental and periodontal issues. Specifically, the records did not enable the PST to understand the gravity of the individual's dental condition, risks of treatments versus not treatment, medical and behavioral complications of the dental condition and under-treatment of the condition, and alternative treatments.

The Facility did not yet have in place dental policies, treatments and meaningful integration of dental services into the team approach to ensure that each individual served by the Facility benefits from appropriate dental services and in the event that standard of care practices cannot be achieved, a clear and rational explanation is well documented in the dental records and personal support plan for the individual, and that regular and robust attempts to provide needed dental services are provided.

Communication

DSSLC has 3.5 positions open but these have not been filled as of this review. Individuals who are need of AAC were still not receiving adequate supports.

Individuals identified as having decreased communication have not consistently been provided with the needed assessments.

Programs in place to assist some individuals are not being consistently implemented. DCPs interviewed were not knowledgeable of the communication programs.

DSSLC was in the process of developing a monitoring process to address the presence and working condition of the AAC device s but were not monitoring whether or not the device was effective and or meaningful to the individual.

Effort focusing on the use of object cards and integration of these cards into life skills training has begun on the Cedar Fall's apartment 502 but no noticeable improvement was yet to be observed. Even in areas where the presence of object cards was noted, there was little to no use of the cards.

Habilitation, Training, Education, and Skill Acquisition Programs

Observations and record reviews reflected substantial limitations in formal assessment and skill acquisition plans. An annual assessment process did typically take place, but the process lacked rigorous and meaningful assessment.

The Facility had made progress in providing community access and opportunities, but this process had not been sufficiently standardized or monitored to allow for a determination of substantial compliance.

Most Integrated Setting

DSSLC had begun implementing the new statewide PSP process, but continued to need improvement in the areas of interdisciplinary assessment, individualized assessment of need for supports and services in the most integrated setting, and development of individualized strategies for education about community living options to promote informed choice.

There was a lack of timely completion of at least one CLDP and failure to provide completed CLDPs in a timely manner prior to the transition as evidenced by MRA documentation that the full CLDPs were not available during the Continuity of Services visit.

The Post-Move Monitor was diligent in her efforts. PMM Checklists were being completed in a timely manner, for the most part, but not universally. There appeared to be some potential for PMM visits to be missed when the process takes place across catchment areas, and the Post-Move Monitor from one SSLC is responsible for the PMM visits for an individual from a different SSLC. There was one such instance found during this compliance visit, and it is an issue that has potential to grow as more individuals move to community settings in other catchment areas.

The Facility did not have in place policies or procedures for alternate discharges. Such alternate discharges could occur at any point, and the Facility should have policies and procedures in place to define its processes. Its plan, according to the POI, was to update its local policy and procedure once anticipated updates to the statewide policy on Most Integrated Setting are completed.

Consent

The Facility was taking a measured approach to the issues of guardianship as it awaited the promulgation of statewide DADS Policy Number: 019 Rights and Protection, and this is to be commended. The Facility expected to operationalize this policy once it was made available. In the interim, the Facility did continue to maintain a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and a LAR to render such a decision, but the placement of the individuals on the list was not made according to any standardized assessment or specific criteria. An informal prioritization process was being used, but it was expected that this would be modified according to the requirements of the statewide policy.

DSSLC had begun to monitor the documentation of the PSP process as it related to discussion of the need for guardianship, which should provide it with a baseline snapshot of the skills of the PSTs in the assessment of ability to provide consent as it begins to operationalize the new statewide policy. These baseline data should be analyzed carefully, as they tended to confirm that the PSTs were not consistently addressing the actual decision-making capacity of individuals before recommending a referral for guardianship, nor were they routinely following up with making a referral once the recommendation has been made.

DSSLC had hired two Human Rights Officers to assist with guardianship and other rights issues; they had not yet started but were scheduled to assume their duties on 10/01/10.

Recordkeeping and General Plan Implementation

DSSLC made progress toward compliance with the requirements of this Section. The new recordkeeping policy and record format had been implemented for nearly all individual records. Training had been provided. An audit process had been put in place that included identification of deficiencies and a procedure to notify staff of corrective actions needed and to follow up on completion. Active Records still did not always include all required documents and had errors such as gaps on pages. Tracking and trending of such errors was not yet in place.

Policy development and revision to support all provisions of Part II of the SA continued at both the statewide and Facility levels.

Use of records for decision-making was variable. In some cases, multiple forms had similar information. Conflicts in information were not resolved. Behavioral program decisions were not supported by data. Not only do the data and other information in the active records need to be available and accurate, there must also be an expectation that the information will be reviewed, discussed, and used.

V. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm- Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DADS Policy #001: Use of Restraint, 8/31/09 2. DSSLC Plan of Improvement (POI) 5/17/10 3. DSSLC Supplemental Plan of Improvement (SPOI) 7/6/10 4. DSSLC Policy CMGMT-20 Limitation of Restraint as a Crisis Intervention dated 11/05/09 5. DSSLC Policy CMGT-03B Drugs For Behavior Intervention dated 4/1/07 6. DSSLC Policy CMGMT-21 Dental/Medical Sedation and Restraint dated 11/05/09 7. Texas Settlement Agreement Monitoring Instrument – Restraints Compliance Report 6/1/10 – 9/29/10. 8. PMAB Training Curriculum 9. Staff Training Records 10. Restraint Checklist and Face-to-Face Assessment/Debriefing Form for Individuals #80 (restraint 7/28/10), #353 (restraint 7/14/10), #581 (restraint 7/14/10), #587 (restraint 7/11/10, 7/12/10 and 8/25/10), #727 (restraint 6/12/10), #372 (restraint 8/10/10), #624 (restraint 7/20/10, 8/2/10, and 8/18/10), #537 (restraint 8/17/10 and 8/31/10), # 172 (restraint 8/16/10 and 8/17/10), #381 (restraint 8/27/10 and 8/30/10), #337 (restraint 8/26/10), and #127 (restraint 8/14/10 three instances). 11. PSP for individual #581. 12. PBSP and Safety Plan Crisis Intervention (SPCI) for individuals #50 (7/22/10), #537 (5/14/10), and #624 (9/9/10). 13. PSP Addendums for individuals #60 (7/23/10), #172 (6/30/10), #537 (6/9/10 and 6/15/10), and #624 (6/17/10 and 6/24/10). 14. SPCIs for individuals #624 (8/3/10) and #50 (6/2/10), 15. Facility restraint log 6/1/10 – 8/31/10. 16. Clinical Justification for extraordinary circumstances for SPCI for individuals #337 and #381. 17. List of individuals receiving pre-treatment sedation March – August, 2010. 18. List of employees injured resulting from restraint application (3/10 – 8/10). 19. List of individuals injured during restraint (3/10 – 8/10). 20. Facility restraint log for medical restraint (7/09 to 2/10) 21. Facility Restraint Analysis report for August 2010. 22. Restraint Reduction Committee minutes May and June 2010. 23. Morning meeting minutes for Timberhill 9/28/10 and 9/29/10, Pine Ridge 8/31/10, Houston Park 8/30/10, Garden Ridge 8/25/10, and Westridge 8/31/10, 24. Incident Management Review Team Meeting minutes for 8/2/10, 8/9/10, 8/16/10, 8/18/10, 8/23/10, 8/30/10, 9/7/10, 9/13/10, 9/20/10, and 9/27/10.

	People Interviewed: 1. Rebecca Wilkins, Director of Quality Assurance 2. Frank Padia, Director of Program Coordination 3. Deb Salsman, Director of Incident Management 4. Tammy Hampton, Incident Manager 5. Randy Spence, Director of Behavioral Services 6. Lori Powell, SA Coordinator 7. Jill Wooten, BCBA 8. Dora Tillis, Assistant Director of Programs 9. Lori Powell, SA Coordinator 10. Elaine Davis. Director of Training and Development **Meetings Attended/Observations:** 1. Incident Management Team 9/27/10 2. Annual PSP for Individual # 209 3. Critical Incident Team meeting 9/30/10 4. Timberhill morning unit meeting 9/29/10.
	Facility Self-Assessment: The DSSLC Plan of Improvement (POI) reported substantial compliance with provision C.8. The monitoring team does not concur and believes a review of the circumstances under which restraint is used must be more substantive and clinically oriented than what was observed. The POI also reported three action steps were in substantial compliance, including the very important action step of having a comprehensive policy on restraint use. The monitoring team concurs that these three action steps are in substantial compliance. For those provisions, and action steps that were reported to not be in compliance DSSLC leadership have formal plans in place to address future progress. Systems of documentation auditing and on the spot in-services are examples.
	Summary of Monitor's Assessment: DSSLC continued to struggle with administrative and clinical systems with respect to restraint use. No chemical restraint has been used since the baseline review. Physical restraint had increased significantly. Two individuals accounted for the majority of restraint use and were clearly outliers that skewed data analysis. Recognizing this, the Facility prepared trend reports that included and excluded them from the data analysis. In reviewing the trend analysis that excluded these two individuals the number of restraints averaged 23 per month over the last four months (May – August, 2010). The number of restraints the prior four months (January – April, 2010) averaged 13 per month. This is a 77% increase in restraint use. Substantive issues with behavior supports discussed in section K will be necessary to ensure restraint use is minimized. Documentation issues with the Restraint Checklist, Face-to-Face Assessment/Debriefing were common. The Facility had an internal auditing/monitoring system that identified many of these issues and provided staff with immediate on-the-spot training.

	The Facility had not addressed the review requirements associated with individuals experiencing restraint more than 3 times in a rolling 30 day period. A template had been developed to accomplish this and was in the very early stage of implementation. The Facility's daily review of restraint episodes was primarily administrative in nature and needed to be more clinically oriented. Staff were current in restraint training and a curriculum review indicated the training presents appropriate content. DSSLC's auditing/monitoring data suggests that improvements in the competency based nature of the training are warranted. The Facility had a process to audit restraint records and provide on-the-spot training to staff. The Facility's Restraint Reduction Committee had become much more active and meeting content appears to be substantive.

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C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	The DSSLC Plan of Improvement POI)reported substantial compliance with the Action Step prohibiting use of prone restraint. The monitoring team concurs. DADS Policy 001 – Use of Restraints prohibits the use of prone restraint. DSSLC policy CMGMT-20, Limitation of Restraint as a Crisis Intervention prohibits use of prone restraint (Section 3-E). The restraint records reviewed did not indicate any use of prone restraint. Staff interviewed were clear in their understanding that prone restraint was prohibited. Restraint training curriculum includes prohibition of prone restraint and all staff training records reviewed indicated staff had completed training courses RES0110 Applying Restraint Devices, RES0105 Restraint: Prevention and Rules for Use of at MR Facilities, and PMAB 4: Restraint. DSSLC is in substantial compliance with this Action Step of the POI. The DSSLC Plan of Improvement reported lack of compliance with all other Action Steps of this provision. The monitoring team concurs with this assessment of status by the DSSLC. In reviewing restraint checklists and face-to-face assessments/debriefings the monitoring team found many examples of deficient practice similar to that found by DSSLC in its internal auditing of restraint records. For example: • Individual #727 was in restraint for 16 minutes (basket hold and horizontal). The restraint checklist indicated that interventions attempted to avoid restraint included interventions specified in a safety plan. Individual #727 does not have a safety plan. The actual date of this restraint is unclear. The "date restraint	N

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		initiated" entry was 6/12/10. The "date released" entry is 6/13/10. The face-to-face assessment/debriefing reported there was a shift change review of restraint (if in restraint at shift change). Individual #727 was not in restraint at shift change. This same document reports that the restraint did not cause injury to anyone when the restraint checklist clearly describes an injury in the RN/LVN Evaluation section. • Individual #372 was in restraint for five minutes (basket hold and horizontal). The action release code indicated release occurred because the individual "met safety plan definition of calm." Individual #372 does not have a safety plan. The post-restraint assessment for injury did not have an entry indicating whether or not an injury occurred. • Individual #624 was in restraint for five minutes (basket hold and horizontal). The restraint checklist indicated the restraint used was specified in a safety plan. The monitoring team confirmed the individual does have a safety plan which specifies basket hold and horizontal restraints. The safety plan also described a set of interventions to be attempted to avoid restraint. The restraint checklist indicated the interventions in the safety plan were not used. There was no entry on the checklist for "reason for restraint". The debriefing documentation indicated that the nurse did not check for injury or check mental status. These checks by the nurse are clearly documented on the restraint checklist. In fact, the individual did incur an injury resulting from the restraint. In all three of the above examples the debriefing document was checked "yes" for "restraint checklist completed correctly" when it was obvious to the monitoring team they had not been. The face-to-face assessment/debriefing document was initiated and completed by a restraint monitor who would be expected to be sufficiently trained to identify errors as obvious as those found by the monitoring team. DSSLC's internal monitoring of restraint documents was in place and was identifying these types of errors for the records sampled. The monitors also provided on the spot retraining to staff as errors were found. The POI acknowledges the need for improvement in restraint implementation and documentation. This was also acknowledged by staff interviewed. The monitoring team is concerned about the components of this provision requiring restraint use in a clinically justifiable manner and not in the absence of or as an alternative to treatment. Because of the deficits in behavior and other programming described in sections J, K, and S the DSSLC cannot assure restraint is always used in a clinically justifiable manner.	

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		The monitoring team is concerned that the use of mechanical devices such as belts, helmets, and mittens be individually sufficiently scrutinized to determine if their use in a particular situation would be considered a restraint in the context of the definition of mechanical restraint in the SA. Individuals #337 and #381 are often in restraint using mittens, wristlets, and anklets. These two individuals have unique circumstances that are discussed in sections J, K, L, and M. Individuals #337 and #381 came to the attention of the monitors due to high frequency of use of mechanical restraints. Restraints were defined as "protective," but met the SA definition of "mechanical restraints." Therefore, they were subject to the review procedures required in the SA. There were other individuals identified (#587) for whom the use of mechanical restraint devices were used and not labeled as mechanical restraint. This subject bears further review by DSSLC and will be reviewed more in depth at the next compliance review by the monitoring team. DSSLC has the necessary policies in place to meet the requirements of the SA. Policy CMGMT-20, Limitation of Restraints as a Crisis Intervention is the overarching policy governing restraint use. Section 3.A.1 limits the use of restraint to crisis intervention if an individual poses an immediate and serious risk of harm to him/herself or others. Section 3.A.2 requires that a graduated range of less restrictive measures be exhausted or considered in a clinically justifiable manner. Section 3.A.4 requires that the use of restraint not be used for punishment, convenience of staff, or in the absence of or an alternative to treatment. Section 3.A.5 requires restraint use to be governed by written policies, procedures, and plans. DSSLC initiated an audit system of restraint related documentation which was beginning to produce compliance reports. The compliance reports can measure compliance with SA monitoring tool data items by living area (apartment), by monitoring tool data item, and by individual. At the time of this review the system had only been in place several months and is still being refined. The Facility has initially adopted an 80% threshold from which to monitor their progress. The Restraint Compliance Report 6/1/10 – 9/29/10 identifies eight areas of compliance that have not as yet reached the 80% compliance threshold. These were C.4.d (authorization for the use of a medical restraint being documented in the individual's PSP and including treatments or strategies to minimize or eliminate the need for such restraint), C.5.c (if a physician orders an alternative monitoring schedule the circumstances were documented and the alternative schedule was followed), C.6.a (checking for restraint related injury), C.6.b (opportunities for exercise of restrained limbs), C.6.c (food provided near mealtimes), C.6.d (fluids offered), C.6.e (opportunity for toileting), C.6.f (continuous 1:1 supervision), C.7.a (all the assessment and documentation required when an individual is in restraint more than three times in a rolling 30 day period). It should be noted that the sample size resulting in these data was limited and much of the error in C.6 was from incomplete restraint checklist and face-to-	

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		face/debriefing entries. Most restraints were of short duration such that opportunities for eating, toileting, and exercise would not be expected.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	DADS policy SectionII.I.1 states" the individual must be released from restraint as soon as he or she no longer poses an immediate and serious risk of harm to him/herself or others. If there is a Safety Plan, the individual will be released according to the instructions that are stated in the Safety Plan (indicators when the individual no longer poses an immediate and serious risk of harm)." DSSLC Policy CMGMT-20 Section 6 contains a similar requirement. The DDSLC POI reported lack of compliance with this provision and the monitoring team concurs. The POI indicated monitoring results over the last six months indicated a compliance rate of 79% citing the lack of accurate documentation and errors in restraint codes being made by staff on the restraint checklist. Release codes on the restraint checklist that would indicate compliance (no longer a danger to him/herself or others) would include J (met safety plan definition), and L (released immediately when no longer immediate and serious risk of harm to self or others). The 20 restraint checklists reviewed by the monitoring team only found one instance of incorrect coding. Individual #372 release code was noted as J but individual #372 does not have a safety plan. It appears DSSLC is moving close to compliance with this provision.	N
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	The DSSLC POI indicated it was in substantial compliance with the component of this provision requiring a comprehensive policy. The monitoring team concurs. DSSLC policy CMGMT-20 and 21 govern the use of restraints. CMGMT-20 addresses crisis intervention, and CMGMT-21 addresses medical sedation and restraint. DSSLC policy CMGMT-20: Section 4.B generally limits approved restraints to that which is described in the statewide PMAB manual. Section 1.A .4 requires that restraint be applied in the safest, least restrictive, most humane, and most respectful way. Section 2.C requires that before working with individual's staff must complete competency training on prevention and de-escalation strategies, restraint techniques and use, and supervision of individuals in restraint. Section 11 provides additional requirements associated with restraint training including a requirement that the staff person demonstrate competency. DSSLC policy CMGMT-21 contains procedures associated with dental/medical pre-treatment sedation and restraint. It includes requirements associated with the Restraint	N

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	have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	Checklist, health care provider roles and responsibilities, monitoring and care (both on and off campus), and strategies to minimize or eliminate the need for medical/dental restraint, including an attachment that describes 13 specific steps that can be taken by the Personal Support Team and home staff in this regard. The DSSLC POI reported lack of compliance with the component of the provision requiring competency based training for staff. The monitoring team concurs. The sample of individual training records reviewed by the monitoring team found restraint training to be current for all employees in the sample; however, data provided by the DSSLC indicated a 97% completion rate for course RES0105 (Restraint: Prevention and Use), a completion rate of 95% for course RES0110 (Applying Restraint Devices), and a completion rate of 94% for course PMA0400 (PMAB 4: Restraint). These completion rates are high enough to consider a determination of substantial compliance. The monitoring team believes the facility may have marked itself as not in compliance because the effectiveness of the training has not been as expected. To address this the facility initiated a process where program auditors/monitors provide on the spot in-services as they identify issues in the course of monitoring. In addition, there did not appear to be any organized training directed at implementation of policy CMGMT-21 (medical restraint). Through interview the facility acknowledged considerable work needed to be done with respect to implementation of this policy and a work group has been formed to address this. The pretreatment sedation process is expected to change significantly and desensitization practices are expected to be developed.	
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 DSSLC POI reported lack of compliance with this provision. The monitoring team concurs. There are two individuals (#337 and #381) for whom restraints are regularly used for reasons other than crisis intervention. These cases are discussed in sections J, K, L, and M. For the most part other instances of restraint appeared to have been limited to crisis intervention. The lack of complete and accurate documentation on restraint checklists and face-to-face assessment/debriefing documents made it difficult to always determine, with a degree of confidence, the actual circumstances around the restraint episode (refer to C.1). It was reported that every instance of restraint use is reviewed in detail in the unit morning incident/injury review meeting and subsequently at the facility wide Incident Management Review Team (IMRT) meeting the same day. The monitoring team believes this to be true although the meetings attended during the review did not include new episodes of restraint. Because of the level of discussion on other topics the monitoring	N

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		team would expect a similar level of discussion would occur when reviewing a restraint episode. It should be noted the meeting minutes ordinarily do not reflect the depth of discussion that occurred at a meeting. To its credit, DSSLC in the POI indicated that it could not rate itself as in compliance because it had an insufficient amount of monitoring data to validate compliance. DSSLC policy CMGMT-21 contains procedures associated with dental/medical sedation and restraint. It includes requirements associated with the Restraint Checklist, health care provider roles and responsibilities, monitoring and care (both on and off campus), and strategies to minimize or eliminate the need for medical/dental restraint, including an attachment that describes 13 specific steps that can be taken by the Personal Support Team and home staff in this regard. Implementation of this policy will need to be tested in future reviews. There did not appear to be any organized activity to implement this policy. Through interview the facility acknowledged considerable work needed to be done with respect to implementation of this policy and a workgroup has been formed to address this. The monitoring team, in its review of PSPs, did not find any instances of treatments or strategies to minimize or eliminate the need for restraint (pre-treatment sedation).	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In	The DSSLC POI reported lack of compliance with this provision. The monitoring team concurs. The compliance monitoring conducted by the DSSLC indicated numerous issues with restraint documentation. This was validated by the monitoring team Three examples are: • Individual #727 was in restraint for 16 minutes (basket hold and horizontal). The restraint checklist indicated that interventions attempted to avoid restraint included interventions specified in a safety plan. Individual #727 does not have a safety plan. The actual date of this restraint is unclear. The "date restraint initiated" entry was 6/12/10. The "date released" entry is 6/13/10. The face-to-face assessment/debriefing reported there was a shift change review of restraint (if in restraint at shift change). Individual #727 was not in restraint at shift change. This same document reports that the restraint did not cause injury to anyone when the restraint checklist clearly describes an injury in the RN/LVN Evaluation section. • Individual #372 was in restraint for five minutes (basket hold and horizontal). The action release code indicated release occurred because the individual "met safety plan definition of calm." Individual #372 does not have a safety plan. The	N

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	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.	post-restraint assessment for injury did not have an entry indicating whether or not an injury occurred. • Individual #624 was in restraint for five minutes (basket hold and horizontal). The restraint checklist indicated the restraint used was specified in a safety plan. The monitoring team confirmed the individual does have a safety plan which specifies basket hold and horizontal restraints. The safety plan also described a set of interventions to be attempted to avoid restraint. The restraint checklist indicated the interventions in the safety plan were not used. There was no entry on the checklist for "reason for restraint". The debriefing documentation indicated that the nurse did not check for injury or check mental status. These checks by the nurse are clearly documented on the restraint checklist. In fact, the individual did incur an injury resulting from the restraint. In all three of the above examples the debriefing document was checked "yes" for "restraint checklist completed correctly" when it was obvious to the monitoring team they had not been. The face-to-face assessment/debriefing document was initiated and completed by a restraint monitor who would be expected to be sufficiently trained to identify errors as obvious as those found by the monitoring team. DSSLC Policy CMGMT-20 Section 5.G requires that a restraint monitor conduct a face to face assessment of the individual as soon as possible but no later than 15 minutes after the start of the restraint to review the application and consequences of the restraint. Section 5.H.2 requires that a licensed health care professional monitor and document vital signs and mental status at least every 30 minutes. Section 5.H.3 extends this requirement to restraints which occur away from the facility. Other provisions of the policy include data items required by the SA. These requirements were not always documented as met, as the following examples of information from restraint checklists demonstrate. • Individual #337 was placed in bilateral wristlets at 1:00 pm on 8/10/10 "for privacy" in the bedroom and was released at 1:55 p.m. The individual was assessed by the nurse at 2:00 p.m., who recorded vital signs as blood pressure of 121/88, pulse rate of 89, and respirations 18. Mental status was alert and no injuries were sustained. • Individual #381 was placed in bilateral wristlets at 10:40 pm on 8/30/10. Assessed by the nurse at 2:45 a.m. who recorded vital signs as blood pressure of 133/94, pulse rate of 98, and respirations 17. Mental status was sleepy and no injuries were sustained. It was not necessary to notify the physician. The wristlets were applied for "bedtime" in the bedroom. The special	

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		instruction was for the nurse not to assess the individual so as not to disturb the until released. The nurse followed the individual's Safety Plan. DSSLC's internal monitoring of restraint documents was in place and was identifying errors for the records sampled. The monitors are also providing on-the-spot retraining to staff as errors are found. The POI acknowledges the need for improvement in restraint implementation and documentation. This was also acknowledged by staff interviewed. There were two instances where a physician had ordered an alternative schedule of monitoring (Individuals # 337 and #383). These cases are discussed in sections J, K, L, and M. The facility reported no instances of restraint occurring while an individual was away from the facility. There was not a practice of physician specification of type and schedule of monitoring required for medical restraints even though this is part of DSSLC policy. It was reported a Medical/Dental Order Form is in the process of being developed. The form would include information on the type and schedule of monitoring when an individual is in medical restraint.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical	The DSSLC Plan of Improvement POI) indicated substantial compliance with the Action Step addressing alternative level of supervision being authorized by the Superintendent in extraordinary circumstances with clinical justification. The monitoring team concurs. The Facility Director had authorized an alternative level of supervision for individuals #337 and #381. In each case the facility director had waived the requirement for 1:1 supervision and extended the time interval for documented observations to every 30 minutes. Both individuals are in mechanical restraints (wristlets and or mittens) for extended periods of time for the prevention of severe self-injurious behavior. These cases are discussed in sections J, K, L, and M., The DSSLC Plan of Improvement indicated lack of compliance with all other Action Steps of this provision. The monitoring team concurs. The POI reports documentation accuracy as a recurring issue. The monitoring team found many examples of this in its review of restraint documentation. Refer to C1 for examples. DSSLC had an organized system for auditing a sample of restraint records every month which included inter-rater reliability checks. Ten records were selected to review. Two of these 10 are reviewed by a second person to ensure reliability. This is a good practice and	N

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	justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	is clearly identifying documentation and practice issues which need to be addressed. The facility had also started a process where the auditors provide immediate feedback to staff in the form of an on-the-spot in service. It was not clear from the monitoring teams review of records whether the on–the-spot in-services are documented in any formal way. The facility has policy which covers all the items noted in this section of the SA. Policy CMGMT-20 Section 5.B contains requirements associated with each element of this section of the SA.	
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 DSSLC POI reported lack of compliance with this provision. The monitoring team concurs. DSSLC had 11 individuals meeting the criteria of 3 or more restraints in a rolling 30 day period. These were individuals #172, #337, #50, #372, #195, #60, #624, #411, #537, #127, and #381. Five of these individuals had a Safety Plan for Crisis Intervention, individuals #337, #50, #624, #537, and #381. DSSLC Policy CMGMT-20 addresses this provision of the Settlement Agreement in section 7.2.c. The monitoring team reviewed PSP addendums for four of the individuals meeting the 3+/30 day criteria. Addendums reviewed were those following the fourth restraint episode. In all cases members of the PSP team met to review recent restraint activity. Most of the PSP addendum documentation reviewed did not reflect the scope of work and degree of specificity contemplated in this provision of the SA. The facility had recently created a PSP Addendum shell to be used in reviewing 3+/30 day restraints. This shell was provided to the monitoring team. It will at least prompt the team to address a-h of provision C7. It is questionable if these elements can be addressed adequately because of the deficient practices discussed in section K.	N
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	Structural and functional assessments were not adequate to identify function or to establish clear hypotheses about functional versus medical and psychiatric factors. Review of adaptive skills was not routinely done as a means of identifying strategies to minimize use of restraint.	N
	(b) review possibly contributing environmental conditions;	Data were not collected in enough detail to determine the cause of behavior provoking restraint. See section K for recommendations regarding functional assessments of behavior.	N
	(c) review or perform structural	Data were not collected in enough detail to determine the cause of behavior provoking	N

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	assessments of the behavior provoking restraints;	restraint. See section K for recommendations regarding functional assessments of behavior.	
	(d) review or perform functional assessments of the behavior provoking restraints;	Data were not collected in enough detail to determine the cause of behavior provoking restraint. See section K for recommendations regarding functional assessments of behavior.	N
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	Data were not collected in enough detail to determine the cause of behavior provoking restraint. See section K for recommendations regarding functional assessments of behavior.	N
	(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	Sampled PSP Addendums would recommend PBSP changes in some cases. See section K for discussion and recommendations regarding deficient practices in PBSP planning.	N
	(g) as necessary, assess and revise the PBSP.	It did not appear that consistent data were being collected with respect to behavioral incidents and interventions. Because of this the relevancy of treatments and supports is	N

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		questionable. In most cases reviewed, the individual went on to have additional episodes of restraint within a short period of time, suggesting whatever actions were taken as a result of the PSP Addendum meeting were ineffective. Refer also to section K.	
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.	PSPs were revised through the use of PSP Addendums. As noted in C.7.f these revisions were for the most part ineffective. For example, even if reviews were done, eight of the 11 individuals who had more than three restraints in a rolling 30 day period remained without safety plans. Individual #172 was restrained eight times in the six weeks following review, and Individual #624 was restrained five times in the seven weeks following review. Furthermore, the use of restraint had increased in the six months since the baseline review. The provision requires that PSPs be revised, as appropriate. When revisions are not made or are not effective, continuing review and consideration of revision is required.	N

Recommendations:

1. Continue the auditing/monitoring activity that has started to produce compliance reports.
2. Continue the practice of immediate retraining of staff as auditors/monitors discover issues. Develop a system to document this training.
3. As more compliance data gets in the system produce compliance reports that can isolate problem areas, e.g. by home/shift and use this analysis to target resource application.
4. Generally improve behavior support services (see section K) so that restraint is used in a clinically justifiable manner.
5. Substantively improve the work processes necessary to achieve compliance with the SA requirements associated with individuals being restrained 3+ times in a rolling 30 day period.
6. Review the definition of mechanical restraint in the SA and assess each individual use of a mechanical device, such as belts, mittens, and wrist and anklets supports, to ensure the use meets the definition for medical restraint rather than mechanical restraint. If the use constitutes a mechanical, rather than medical, restraint, ensure that proper restraint review and documentation procedures are followed.
7. Substantively improve the work processes necessary to properly implement CMGMT-21 (medical and dental pre-treatment sedation).
8. Ensure all restraint monitors are competency based trained and develop a mechanism to validate ongoing competency.
9. Engage in interdisciplinary activity to improve services to individuals #337 and #381 (see sections J, K, L, and M).
10. Develop mechanisms to ensure review of individual restraint episodes have sufficient clinical orientation.
11. If the Unit Meetings and IMRT meetings continue to be the "official" mechanism to achieve the 3 day review required by the SA modify practice to ensure committee members have actual documents to review.

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DADS Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation 6/18/10 2. DADS Policy 02.2 Incident Management 6/18/10 3. DADS Policy 01 Use of Restraint dated 8/31/09 4. DADS Policy 042.3 Video Surveillance 8/6/10 5. DSSLC Plan of Improvement 5/17/10 6. DSSLC Supplemental Plan of Improvement 7/6/2010 7. DSSLC Policy CMGMT-01A Protection from Harm – Abuse, Neglect, and Exploitation 7/30/10 8. DSSLC Policy CMGMT-01B Protection from Harm – Incident Management 7/30/10 9. DSSLC Policy CMGMT-20 Limitation of Restraint as a Crisis Intervention dated 11/05/09 10. DSSLC Policy CMGT-03B Drugs For Behavior Intervention dated 4/1/07 11. DSSLC Policy CMGMT-21 Dental/Medical Sedation and Restraint dated 11/05/09 12. DSSLC Policy Client Management-28 2/23/10 – Guidelines for Staff Interaction with Individuals 13. DSSLC Policy Client Management-01B Injuries to Persons Served in Residential Programs 3/1/09 14. DSSLC Policy Client Management-01C Reporting, Documenting, and Review of Unusual Incidents 6/8/09 15. DSSLC Policy Client Management-07 Absence Accountability, dated 6/1/06 16. U.S. DHHS Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment 3/10/06 17. List of individuals with bedrails and bedrail related injuries 4/1/10 – 9/30/10 18. Training Curriculum for Course ABU0100 Abuse and Neglect 7/13/09 19. DSSLC Retraining Curriculum for Course ABU0100 Abuse and Neglect 7/20/10 20. Memory Jogger (undated) for SNIPP abuse reporting procedure 21. Sample of Employee Training Records 22. DADS Report MHMR0102 Percent of All Employees Completing Courses of Training Program 9/1/10 23. DADTX Course Due/Delinquent Report for DSSLC 9/29/10 24. Sample of Acknowledgment of Responsibility for Reporting Abuse, Neglect, and Exploitation employee forms. 25. DSSLC Annual Employee Registry Check and Fingerprint Criminal History Check 9/10/10 26. Emails indicating Facility Director notification when employees are arrested and don't self report 9/27/10 27. Letters to employees validating administrative disciplinary action discharge after confirmed cases of abuse/neglect 7/13/10. 8/12/10, 3/30/10.4/14/10, 8/6/10, 8/18/10 28. "You Have the Right" poster 1/17/09 29. Rights Poster Audit 9/30/10

	30. Current mailer to LARs regarding abuse, neglect, and exploitation 31. Morning meeting minutes for Timberhill 9/28/10 and 9/29/10, Pine Ridge 8/31/10, Houston Park 8/30/10, Garden Ridge 8/25/10, and Westridge 8/31/10 32. Incident Management Review Team Meeting minutes for 8/2/10, 8/9/10, 8/16/10, 8/18/10, 8/23/10, 8/30/10, 9/7/10, 9/13/10, 9/20/10, and 9/27/10 33. Incident Auditor Under Reporting audits for 8/10 and 9/10 34. Trend Analysis Report 8/31/10 35. Trends Analysis Committee meeting minutes 9/16/10 36. Individual Training Records for Facility and Department of Family and Protective Services (DFPS) Investigators 37. Incident Log 4/1/10 – 9/7/10 38. Peer Caused Injury report 5/1/10 – 9/18/10 39. Client Injury Assessments for Individuals #204 (9/2/10), #752 (9/3/10), and #141 (9/2/10). 40. Serious Injury Report 7/10/10 to 9/27/10 41. Injury Summary (by individual) 4/1/10 – 9/28/10 42. Discovered Injury Investigation for Individuals #406 and #686 43. Investigation Review/Approval form for UIR 11-012, 10-368, and 10-366 44. Top 10 Aggressors (Individuals who caused injuries to other individuals) 4/1/10 to 9/29/10. 45. UIRs 10-361, 11-013, 10-357, 10-370, 10-341, 10-357, 10-329, 10-372, 10-322, 10-314, 10-307, 10-309, 10-355, 10-295, 10-298, 10-299, 10-318, 10-327, 10-271, 10-129, 10-231, 10-285, 10-254, 10-284, 10-286, 10-244, 10-283, 10-282, 10-143, 10-159, 10-144, 10-214, 10-262, 10-280, 10-152, 10-132, 10-329, 10-246, 10-258 46. Top 10 Injured Individuals 4/1/10 to 9/29/10 47. Instructions for Completion of Unusual Incident Investigation Form 48. Investigation Review/Approval Form 49. DFPS Investigation Reports 36802089, 36819250, 36998409, 37058029, 37459680,37478460, 36725849, 37675280, 36998409, 37081409, 37495160, 37709400, 36516050, 36552429, 36578430, 36598491, 37640620, 37565560, 36682150, 36607449, 37269091, 36896930, 36779596, 36816329, 37472562, 37449740, 37405660, 37346300, 37324540, 37321500, 37321520, 37309100, 37308102, 37252420, 37269091, 37242440, 37190531, 37239460, 37183470, 37148231, and 37146350 50. DSSLC Incident Management Team Review signoff form for DFPS case 37709400 51. Tracking log from Client Abuse Neglect Reporting System (CANRS) showing employee discipline 9/28/10 52. List of approved evidence custodians 9/29/10 53. Evidence Chain of Custody form for UIR 10-271 54. Email from DFPS containing policy/procedures for streamlined investigations 9/28/10 55. List of individuals for whom DFPS conducts a streamlined investigation 56. DSSLC Family Association meeting minutes 4/25/10 and 6/27/10Self Advocacy meeting minutes 4/27/10, 5/25/10, 6/29/10, and 7/27/10. 57. DSSLC CMS2567 7/22/10 and 6/15/10

	People Interviewed: 1. Rebecca Wilkins, Director of Quality Assurance 2. Frank Padia, Director of Program Coordination 3. Deb Salsman, Director of Incident Management 4. Tammy Hampton, Incident Manager 5. Randy Spence, M.S.,Director of Behavioral Services 6. Elaine Davis. Director of Training and Development 7. Dora Tillis, Assistant Director of Programs 8. Lori Powell, SA Coordinator 9. Andy Maher, Director of Consumer and Family Relations 10. Nora Brookins, Incident Auditor 11. Three Direct Care Professions and two direct contact support staff **Meetings Attended/Observations:** 1. Incident Management Team. 9/27/10 2. Annual PSP for Individual # 209 9/29/10 3. Critical Incident Team meeting 9/30/10 Timberhill morning unit meeting 9/29/10.
	Facility Self-Assessment: The DSSLC POI reported substantial compliance with 23 of 73 Action Steps. None of the five provisions in Section D were rated as in substantial compliance in their entirety. The monitoring team, for the most part, concurred with the DSSLC Self-Assessment although there were Action Steps where the monitoring team determined substantial compliance despite the facility report of noncompliance. This includes Action Steps related to ensuring alleged perpetrators of abuse are removed from individual contact and reassigned to non-contact work areas; the posting of Rights Posters throughout the facility; and, procedures for referral of incidents, as appropriate, to law enforcement. Particularly noteworthy is reported substantial compliance with abuse/neglect training requirements. DSSLC reported substantial compliance and the monitoring team was able to confirm substantial compliance. The DSSLC POI consistently indicated a reluctance to assert substantial compliance because "there has not been enough monitoring over a period of time to show compliance." Most monitoring began in August and consists of small sample sizes. The facility's acknowledgement that it should not report substantial compliance until it has sufficient data, over time, to validate compliance is appreciated by the monitoring team.
	Summary of Monitor's Assessment: DSSLC had a well-organized system for abuse prevention, detection, and reporting and a well-organized and managed system for incident management. The implementation of a video surveillance system in June

	2010 was a significant enhancement that resulted in a substantial increase in reported allegations with investigations confirming significantly more allegations. DSSLC had done a good job training its staff in abuse and neglect. The monitoring team was able to validate substantial compliance with this Action Step. DSSLC is a very large facility and there are things that occasionally "fall through the cracks". Those identified by the monitoring team are noted in the report but they did not represent large numbers or alarming issues. Management systems are under continual refinement to minimize this. There was clearly a problem with timely response from DFPS in initiating investigations. Initial investigatory activity often exceeded the 24 hour requirement, sometimes by days. Compliance with required background checks was confirmed.

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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 DSSLC POI indicated it was not in compliance with this provision. The monitoring team concurs. The POI indicated that DSSLC has not done enough compliance monitoring over a sufficient period of time to feel assured of compliance. It also noted that the monitoring that has been done identified occasional delays in staff reporting allegations within specified timeframes. The monitoring team reviewed 40 UIR's and 45 DFPS case reports. For the most part allegations were reported within the specified timeframe. The monitoring team found one instance of untimely reporting which was documented by DADS Regulatory in a CMS 2567 document. An incident of inappropriate sexual behavior (which could possibly have resulted from employee neglect) occurred during the 2-10 shift on 6/8/10. It was not reported internally (to a QMRP) until 5:15am the next day, and not reported to DFPS until 10:19am. DSSLC has implemented a system of UIR auditing/monitoring. Samples of 10 UIRs were reviewed each month. This audit checks, among other things, timeliness of reporting. This process is relatively new and is expected to, over time, increase the accuracy of UIRs. DADS reissued its abuse and neglect policies on 6/18/10. Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation and Policy 02.2 Incident management supersede Policy 02.1 which covered both topics. Policy 2.2 includes as an exhibit the Memorandum Of Understanding between DADS, OIG, and DFPS. These policies include changes resulting from recommendations from the monitoring team's baseline reviews and	N

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		clearly reflect an absolute prohibition of abuse and neglect and require timely reporting. DSSLC reissued its policies on 7/30/10 to reflect changes in the State policy. DSSLCs governing policies are now CMGMT 01A – Protection From Harm – Abuse, Neglect, and Exploitation, and, CMGMT 01B – Protection From Harm – Incident Management. A video surveillance system was installed at the DSSLC that went into effect in June, 2010. The system appears to have had a significant impact on the number of reported incidents and the number of confirmed allegations. Since the cameras have been in use the facility has averaged 32 allegations of abuse per month. In the three months prior to the installation of the video surveillance system the facility averaged 13 allegations of abuse. The number of confirmed allegations of abuse has tripled. There were 9 confirmed cases of abuse in the 3 months that cameras have been in place (June, July, and August, 2010). In the prior 3 months (March, April, and May 2010) there were 3 confirmed cases of abuse. Most DFPS investigation reports completed since June, 2010 identified the surveillance disc as a piece of evidence.	
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:	The DSSLC POI for this provision includes 36 Action Steps. Twenty-six were rated by DSSLC as lacking compliance and 10 were rated as in substantial compliance. Therefore, this provision cannot be rated as being in substantial compliance. The monitoring team is in general agreement with this self assessment with any deviations noted in the subsections to follow. DADS reissued its abuse and neglect policies on 6/18/10. Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation and Policy 02.2 Incident management supersede Policy 02.1 which covered both topics. These policies include changes resulting from recommendations from the monitoring team's baseline reviews. DSSLC reissued its policies on 7/30/10 to reflect changes in the State policy. DSSLCs governing policies are now CMGMT 01A – Protection From Harm – Abuse, Neglect, and Exploitation, and, CMGMT 01B – Protection From Harm – Incident Management.	N
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as	The DSSLC POI reported a lack of compliance for this Action Step. The monitoring team concurs. The POI stated all staff had not been trained on incident management policies. The POI also stated that because changes have been recent there has not been enough compliance monitoring over a sufficient period of time to assure compliance. Monitoring started in August, 2010. Finally, the POI indicated that its monitoring had discovered instances of untimely reporting. The monitoring team, in its review of a sample of employee training records, found two employees who had not had the UNU0100 class in a timely manner.	N

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	warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	The monitoring team identified one instance of untimely reporting which was documented by DADS Regulatory in a CMS 2567 document. An incident of inappropriate sexual behavior (which could possibly have resulted from employee neglect) occurred during the 2-10 shift on 6/8/10. It was not reported internally (to a QMRP) until 5:15am the next day, and not reported to DFPS until 10:19am. CMGMT-01A Section IV.A requires immediate (and in no case more than one hour after suspicion or after learning of the incident) notification to DFPS of any suspected act of abuse, neglect, or exploitation. This policy also requires immediate notification of the Facility Director, or designee, in order to begin the process of implementing client protection measures, securing evidence where appropriate, beginning an investigation and any other administrative actions deemed appropriate to the circumstances. Through interview and document review it was apparent DSSLC had a standardized reporting system for incidents. The daily meetings of the Incident Management Team and the comprehensiveness of other documents used in the reporting and review process, such as home logs, appeared to be effective mechanisms to quickly identify most issues that should have been reported and may not have been and to examine causation factors if any incident was reported late.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	The DSSLC POI reported a lack of compliance for this Action Step. The POI stated that there has not been enough compliance monitoring over a sufficient period of time to assure compliance. Monitoring started in August, 2010. The monitoring team determined that DSSLC is in substantial compliance with this provision. CMGMT-01A Section III described immediate steps that must be taken to protect individuals, assess and treat injury, and secure evidence, and remove the alleged perpetrator from the scene. A review of a sample of 40 incident reports, observation of the Incident Management Review Team meeting, and staff interviews confirm that alleged perpetrators are always reassigned away from client contact job responsibilities.	SC
	(c) Competency-based training, at	The DSSLC POI reported substantial compliance with this Action Step. The monitoring	SC

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	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.	team concurs. CMGMT-01A Section II requires all staff to attend competency based training on preventing and reporting abuse and neglect pre-service and every twelve months. It also requires that supervisors will periodically assess employee knowledge and provide additional training as needed. A review of the curriculum confirmed that relevant and appropriate topics are covered in the training. A DADS report indicating the percentage of completion for various training requirements indicated 98% of DSSLC employees were current with course ABU0100 – Abuse and Neglect. A "course due/delinquent" report identified the 27 employees (of 1684) who were, or would soon be, delinquent in this training. The Competency-Based Training Department uses this report to ensure follow-up. The monitoring team reviewed a sample of approximately 50 Individual Training Records. This further validated compliance. Of the records sampled all were current. The monitoring team reviewed the training curriculum (and the curriculum used for annual retraining) and found it to be comprehensive and competency based. It included multiple testing methods that would ensure, if the tests were passed, sufficient comprehension to follow the abuse/neglect policy. DSSLC had at least two mechanisms to test staff knowledge post training. Training staff use a "memory jogger" while visiting residential settings, and, program auditors query staff when they are conducting focused sampling of residential areas. Finally, the monitoring team queried several staff as to their knowledge of the abuse/neglect reporting requirements. This final check to validate substantial compliance yielded correct responses from the staff.	
	(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	The DSSLC POI reported lack of compliance with this Action Step with the exception of component number 2 in the POI which addressed new employees receiving abuse/neglect training as part of new employee orientation. The POI indicated there has not been enough compliance monitoring over a sufficient period of time to assure compliance. Monitoring started in August, 2010. The monitoring team concurs that number 2 is in substantial compliance. The monitoring team also determined that numbers 3, 4, 5, and 6 in this Action Step are in substantial compliance. The monitoring team sampled 20 employee records to find the signed statements	N

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	their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	acknowledging reporting responsibilities. The signed statement were in place for 100% of the sample. The POI did not address the final topic of this provision which addresses appropriate personnel action in response to a mandatory reporter's failure to report abuse/neglect. Through interview one example was described however no follow-up documentation was provided to the monitoring team.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	The DSSLC POI reported a lack of compliance for this Action Step. The monitoring team concurs. CMGMT-01A Section I.M requires that the DSSLC provide a training and resource guide regarding signs of and how to report abuse, neglect, and exploitation of individuals to the individuals served, their primary correspondents, and their legally authorized representative (LAR). Evidence was produced to show that the Resource Guide is sent to LARs. There does not seem to be sufficient effort in educating individuals living at the DSSLC on issues related to abuse/neglect reporting. The monitoring team did not observe any discussion of this topic at PSP meetings attended. None of the PSP documents reviewed documented any discussion of this topic. Minutes from the last 4 meetings of the Self Advocacy group did not reflect discussion of this topic. DSSLC has many individuals capable of understanding basic elements of abuse and neglect identification and reporting. They should be considered as members of the client protection team at DSSLC.	N
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	The DSSLC POI reported a lack of compliance with 2 of 3 components of this Action Step. The POI stated that there has not been enough compliance monitoring over a sufficient period of time to measure compliance. The monitoring team determined that the DSSLC is in substantial compliance with this element of this provision. The auditing activity conducted by the DSSLC validated that rights posters are, for the most part, in place. The POI indicated this monitoring has not been in place for a sufficient period of time to assert substantial compliance. Data reviewed by the monitoring team, including a recent 100% site survey conducted by the DSSLC program auditors the week of the monitoring review, validated substantial compliance with the requirement for posting of the rights document. The 3rd element of the Action Step indicated DSSLC will interview individuals to ensure	SC

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		they are aware of the posters and understand how to report rights violations. This appears at best to be an informal process with no documentation to validate the work effort or its effectiveness. This section of provision D.2 addresses the content of the poster only, not efforts to educate individuals beyond making the poster available and easy to understand. Education of individuals is addressed in D.2.e.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The DSSLC POI reported a lack of compliance with 1 of 2 elements of this Action Step. The POI stated that there has not been enough compliance monitoring over a sufficient period of time to measure compliance. The monitoring team determined the DSSLC to be in substantial compliance. DSSLC did not rate itself as in compliance because the monitoring system in use has not been of sufficient duration to measure compliance over time. The monitoring team did not find, in its review of 45 DFPS cases and 40 UIRs, any instance of an incident not reported to law enforcement that should have been. In addition, the most recent Memorandum of Understanding (MOU) between DADS, OIG, and DFPS provides a policy framework for routine assessment by DFPS of the need to refer a case to law enforcement. The MOU is part of the DADS policy on Incident Management.	SC
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	The DSSLC POI reported a lack of compliance for this Action Step. The monitoring team concurs. DSSLC has developed a monitoring tool that includes queries regarding retaliation. Until this tool produces data over a period of time DSSLC does not feel it can self assess substantial compliance. DSSLC abuse/neglect training included subject matter addressing this topic. DSSLC reports it has investigated, informally, a few instances of an employee being in fear of retaliation although not actually having been retaliated against. One such complaint resulted in Denton police officers interviewing several staff. DSSLC investigation staff believed this sent a strong message to staff about the seriousness of retaliation and the facility's willingness to follow-up to protect employees. The Facility should consider addressing how it reviews and investigates alleged acts of retaliation and perhaps develop a more formal process. CMGMT-01A Section IX contained the necessary elements to comply with this section of the SA. It included resources with phone numbers that persons can access if they feel there are concerns with regard to retaliation that are not being addressed at the facility level.	N

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	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The DSSLC POI reported substantial compliance with 2 of 3 components of this Action Step. The POI stated that there has not been enough compliance monitoring over a sufficient period of time to measure compliance. The monitoring team concurs. DSSLC has developed a monitoring tool that assesses under-reporting. Until this tool produces data over a period of time DSSLC does not feel it can self assess substantial compliance. Additionally, the number of file reviews to detect potential under-reporting needs to be expanded to a sample large enough from which results can be generalized. The current system consists of 8 audits a month. The auditor reviews the individual records, especially nursing notes and progress notes, to identify entries that should have resulted in an injury report. If an injury report is found the auditor determines if the entries are consistent with notes found in the record. If no injury report is found the auditor follows-up to injury an injury report, albeit quite late, is generated with appropriate backup documentation.	N
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:	The DSSLC POI for this provision includes 28 Action Steps. Sixteen were rated by DSSLC as lacking compliance and 12 were rated as being in substantial compliance. Therefore, this provision cannot be rated as substantial compliance. The monitoring team is in general agreement with this self assessment with any deviations noted in the subsections to follow. DADS reissued its abuse and neglect policies on 6/18/10. Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation and Policy 02.2 Incident management supersede Policy 02.1 which covered both topics. These policies include modifications resulting from recommendations from the monitoring team's baseline reviews. DSSLC reissued its policies on 7/30/10 to reflect changes in the State policy. DSSLCs governing policies are now CMGMT 01A – Protection From Harm – Abuse, Neglect, and Exploitation, and, CMGMT 01B – Protection From Harm – Incident Management. DSSLC Policy CMGMT 01B – IX establishes an administrative review process for discovered injuries that are not classified as serious. This is important because minor discovered injuries can result from abuse or mistreatment of individuals.	N
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified	The DSSLC POI reported substantial compliance for three of four components in this Action Step. The POI indicated there has not been enough compliance monitoring over a sufficient period of time to measure compliance. Monitoring started in August, 2010.	N

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	investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The POI reported substantial compliance with respect to the training investigators have received. The monitoring team does not concur. DSSLC investigators training records indicate completion with all required training mandated in CMGMT 01B Section III. DFPS investigators training records were not clear. DFPS provided the monitoring team with a set of materials dated June 3, 2010 outlining their organization structure and training requirements. Page 9 describes training requirements. These requirements are Instructor Lead Skills Development (ILSD) and advanced ILSD (ILASD). In addition, according to this document DFPS investigators are required to take Field Training which consists of 2 web-based training modules. The monitoring team was provided with Individual Training Records for 6 DFPS investigators. Two of 6 records included the 3 referenced courses: 0001189 MH&MR Investigations ILASD, 0001188 MH&MR Investigations ILSD, and 0001177 APS MH&MR Investigations Field Training One. Records for the other 4 investigators included related course such as 0001273 MH&MR Overview-APS Investigator Role and 0001228 MH&MR 4000-Case Closure Policy in a Box. It is not clear if these two courses predate ILSD and ILASD and can be considered as equivalencies, or if these investigators had not completed required training. A review of the DSSLC Table of Organization shows DSSLC investigators are not in the direct line of supervision of alleged perpetrators. In the event a staff person in the investigation department was to be named as an alleged perpetrator the DSSLC has trained the Lead Campus Coordinator to conduct investigations to avoid such a conflict. CMGMT 01B Section VI provided policy/procedural direction for the conduct of facility based investigations. Supplemental guidance is contained in the Training Manual investigators receive from the state mandated training they attend. This manual includes sections on the investigative process, organizing an investigation, physical and demonstrative evidence, testimonial evidence, documentary evidence, and, drawing conclusions and reporting investigative findings.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The DSSLC POI reported substantial compliance for one of three components in this Action Step. The monitoring team concurs. The POI indicated there has not been enough compliance monitoring over a sufficient period of time to measure compliance. Monitoring started in August, 2010. The POI stated that there are occasional reports of staff not cooperating with outside entities. One DFPS case report reviewed by the monitoring team had an explicit reference to a staff person not cooperating and noted needed intervention from facility administration.	N

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	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The DSSLC POI reported substantial compliance for one of two components in this Action Step. The monitoring team concurs. The POI indicated there has not been enough compliance monitoring over a sufficient period of time to measure compliance. Monitoring started in August, 2010. Investigations that require substantive coordination with law enforcement are not common. The absence of a broader experiential base makes it difficult to assess compliance with this Action Step.	N
	(d) Provide for the safeguarding of evidence.	The DSSLC POI reported substantial compliance for one of two components in this Action Step. The monitoring team concurs. The POI indicated there has not been enough compliance monitoring over a sufficient period of time to measure compliance. Monitoring started in August, 2010. DSSLC has a locked evidence cabinet. DSSLC has identified 14 staff as evidence custodians. This includes personnel from DSSLC security and facility investigators. DSSLC has an Evidence Chain of Custody Form. The monitoring team reviewed the form associated with UIR 10-271 and found it acceptable. Investigations that require safeguarding of physical evidence are not common. The evidence cabinet has only been used one time. The recency of establishing this process and resulting absence of a broader experiential base makes it difficult to assess compliance with this Action Step at this time.	N
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation,	The DSSLC POI reported substantial compliance for two of five components in this Action Step. The POI indicated there has not been enough compliance monitoring over a sufficient period of time to measure compliance. Monitoring started in August, 2010. The monitoring team concurs. Additionally, the monitoring team does not concur with one of the two items reported as substantial compliance. One component reported in substantial compliance was "investigations of serious incidents resulting in a written report." The monitoring team reviewed 45 DFPS case reports and 40 DSSLC UIRs. All consisted of written reports including a summary of the investigation, findings, and, as appropriate, recommendations for corrective action. This component is in substantial compliance. The other component reported in substantial compliance was "investigation of a serious incident commence within 24 hours…..completed within 10 calendar days." This was not	N

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	findings and, as appropriate, recommendations for corrective action.	always the case. Investigations conducted by DSSLC, as validated by UIR documentation, always commenced within 24 hours. Most started immediately upon being reported. DSSLC had a system where a trained investigator is on-duty (on campus) 24 hours a day, seven days a week. DSSLC had also added a nurse investigator to its staff to improve the quality of investigations involving suspicious injuries or medical care. Facility investigation reports (UIRs) reviewed were all completed within the 10 day timeframe. Investigations conducted by DFPS did not always commence within 24 hours of being reported. For example, case 37459680 (confirmed physical abuse) was reported to DFPS on 8/16/10 at 5:54am. The initial face-to-face interview was done on 8/17/10 at 1:05pm. This was approximately 31 hours after being reported. Case 37616000 (unconfirmed neglect) was reported to DFPS on 8/25/10 at 11:11am. The initial face-to-face assessment was done on 8/26/10 at 2:15pm. This was approximately 27 hours after being reported. Case 36802089 (confirmed physical abuse) was reported to DFPS on 6/25/10 at 11:10am. The initial face-to-face interview was done on 6/28/10 at 3:28pm. This was approximately 3 days after being reported. Case 37058029 (unconfirmed neglect) was reported to DFPS on 7/16/10 at 5:27pm. The initial face-to-face assessment was done on 7/19/10 at 12:00pm. This was approximately 2 days after being reported. Case 36725849 (confirmed physical abuse) was reported to DFPS on 6/18/10 at 3:13pm. The initial face-to-face assessment was done on 6/21/10 at 2:23pm. This was approximately 3 days after being reported. DFPS investigations are not always completed in 10 days. For example, case 36516050 (inconclusive physical abuse) was reported on 6/1/10. The DFPS report is dated 6/21/10. Case 37675280 (confirmed neglect) was reported on 8/28/10. The DFPS report is dated 9/9/10. Case 37058028 (unconfirmed neglect) was reported on 7/16/10. The DFPS report is dated 7/29/10. In each case there is a notation in the report indicating an extension request was made but there is not any indication if the extension was granted or a description of what extraordinary circumstance necessitated the extension request.	
	(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	The DSSLC POI reported substantial compliance for one of two components in this Action Step. The POI indicated there has not been enough compliance monitoring over a sufficient period of time to measure compliance. Monitoring started in August, 2010. The monitoring team has determined this Action Step to be in substantial compliance. There should be a large enough sample used in DSSLC monitoring of reports to be able to generalize review results that demonstrate compliance. Additionally, the	SC

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	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.	auditing/monitoring completed to date is limited to DSSLC UIRs. This needs to be expanded to include audits of DFPS investigations. CMGMT-01B Section VI and VII provided specific requirements associated with investigations conducted by DSSLC staff. CMGMT-01A Section VI and VII provide specific requirements associated with investigations conducted by DFPS. Reports use a standardized format and from those reviewed by the monitoring team generally contain the data elements required by the SA.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	The DSSLC POI reported substantial compliance for one of three components in this Action Step. The POI indicated there has not been enough compliance monitoring over a sufficient period of time to measure compliance. Monitoring started in August, 2010. The monitoring team concurs that this is a brief time to measure compliance. Although the monitoring team finds the Facility to be in compliance currently, this will be monitored at future compliance visits to ensure continuing compliance. Staff supervising investigations (the Incident Management Coordinator) reviews all investigation reports. This review is documented on a form entitles "Investigation Review/Approval Form." The form also includes space for the Facility Director to note comments, if any, and signoff documented her review of the investigation report. This review, as stated on the form, is to ensure the investigation report is thorough and complete, accurate and coherent, and any deficiencies in the investigation or report are addressed promptly. In a limited review of these forms it was evident that the both the	SC

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		Incident Management Coordinator and the Facility Director had made substantive entries indicating a thorough review. In addition to the above process all investigation reports are reviewed by the Incident Management Review Team (IMRT) and IMRT minutes confirm these reviews take place. This review is also documented in each specific incident/investigation file using a form entitled Incident Management Team Review of DFPS Investigations. The monitoring team did not sample enough documents during this review to validate substantial compliance; however, the monitoring team is satisfied that a sound management practice to achieve this is in place at the DSSLC.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The DSSLC POI reported substantial compliance for one of three components in this Action Step. The POI indicated there has not been enough compliance monitoring over a sufficient period of time to measure compliance. Monitoring started in August, 2010. The monitoring team reviewed documentation of report review and the reports that document this review and determined substantial compliance for this Action Step.	SC
	(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.	The DSSLC POI reported lack of compliance with this Action Step. The POI indicated there has not been enough compliance monitoring over a sufficient period of time to measure compliance. Monitoring started in August, 2010. The facility indicated it had recently revised the UIR tracking process to facilitate improvement in tracking implementation of recommendations made as a result of IMRT, IMC, and/or Facility Director review of investigation reports. Tracking of programmatic action to completion is not yet fully in place.	N
	(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.	The DSSLC POI reported substantial compliance for one of two components in this Action Step. The POI indicated there has not been enough compliance monitoring over a sufficient period of time to measure compliance. Monitoring started in August, 2010. A review of investigation files maintained in the Incident Managers office confirmed a well organized and accessible system for maintaining files. The monitoring team has determined this Action Step to be in substantial compliance.	SC
D4	Commencing within six months of	The DSSLC POI reported lack of compliance with this Action Step. The POI indicated there	SC

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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.	has not been enough compliance monitoring over a sufficient period of time to measure compliance. Monitoring started in August, 2010. The monitoring team concurs that this is a brief time to measure compliance. Although the monitoring team finds the Facility to be in compliance currently, this will be monitored at future compliance visits to ensure continuing compliance. DADS reissued its abuse and neglect policies on 6/18/10. Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation and Policy 02.2 Incident management supersede Policy 02.1 which covered both topics. These policies include modifications resulting from recommendations from the monitoring team's baseline reviews and clearly reflect an absolute prohibition of abuse and neglect and require timely reporting. DSSLC reissued its policies on 7/30/10 to reflect changes in the State policy. DSSLC governing policies are now CMGMT 01A – Protection From Harm – Abuse, Neglect, and Exploitation, and, CMGMT 01B – Protection From Harm – Incident Management. CMGMT-01B Section XI contains the requirements for tracking and trending that will enable this element of the SA to be met. The data collection and report production processes appear to be in place. Reports are not, as yet, being regularly used for detailed data analysis and management decision-making. The data system appeared to be capable of disaggregating data into finite sections, such as by home by shift by day of week. In other words, if an administrator wanted to examine incidents that occur on a particular home on second shift on weekends the data system should be able to produce a report displaying these data.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working	The DSSLC POI reported substantial compliance for one of two components in this Action Step. The POI indicated there has not been enough compliance monitoring over a sufficient period of time to measure compliance. Monitoring started in August, 2010. The component reported in substantial compliance was the assertion of 100% compliance with background checks for both staff and volunteers (who work directly with individuals). The monitoring team reviewed documentation associated with this and was able to confirm substantial compliance. The monitoring team reviewed a spreadsheet entitled "Denton SSLC Annual Employee Registry Check and Fingerprint History Check." This report consolidated data from the Employee Misconduct Registry (as of 9/3/10) , the Nurse Aid Registry (as of 9/3/10), the DADS Client Abuse, Neglect Registry System (as of 9/10/10), and background fingerprint Dates for what was represented as all DSSLC staff. The monitoring team accepts this spreadsheet as suitable documentation for measuring compliance with this provision.	SC

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	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.	In order to validate that all DSSLC employees were listed on the spreadsheet the monitoring team was provided a list of all current employees. A sample of 25 was compared to names on the spreadsheet. All of the 25 names on the list of current employees were not on the spreadsheet. There were six volunteers identified that regularly worked with individuals. Background check documentation was provided for three. Although the monitoring team found this provision to be in substantial compliance, continued compliance will require that a corrective action be taken to ensure background checks for volunteers are done as required.	

Recommendations:
1. Continue and expand the auditing/monitoring system that has been put in place. Include auditing of DFPS case reports. Draw larger samples where possible.
2. In conjunction with the Quality Assurance Department develop refinements to the data base that can produce very specific reports isolating data to multiple specific variables such as: home, day of week, shift.
3. Work with DFPS administration on time related responsiveness necessary to meet the requirements of the SA.
4. The Facility must take corrective action to ensure background checks for volunteers are done as required.

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:** **Documents Reviewed:** 1. DADS Policy 003-Quality Enhancement 2. DSSLC Plan of Improvement 5/17/10 3. DSSLC Supplemental Plan of Improvement 7/6/2010 4. DSSLC Policy CMGMT-15 Quality Enhancement Process, dated 1/5/10 5. DSSLC Draft QA Plan 6. DSSLC Quality Assurance/Quality Improvement Council Meeting: Data Analysis Report 9/23/10. 7. Short/Long Term Plan for each section of the SA (undated). 8. Monitoring tools and Compliance Reports for each provision of the SA (various dates). 9. Trend Analysis Committee minutes 9/16/10. 10. Trend Analysis Report August 2010. 11. Performance Improvement Council (PIC) minutes 6/18/10, 7/19/10, and 8/18/10. 12. Memory Joggers (undated) **Persons Interviewed:** 1. Rebecca Wilkins, Director of Quality Assurance 2. Frank Padia, Director of Program Coordination 3. Deb Salsman, Director of Incident Management 4. Tammy Hampton, Incident Manager 5. Randy Spence, Director of Behavioral Services 6. Elaine Davis. Director of Training and Development 7. Dora Tillis, Assistant Director of Programs 8. Lori Powell, SA Coordinator **Meetings attended/Observations:** 1. Incident Management Team 9/27/10 2. Annual PSP for Individual #209 3. Critical Incident Team meeting 9/30/10 4. Timberhill morning unit meeting 9/29/10
	Facility Self-Assessment: The DSSLC POI reported it was not in substantial compliance with any of the provisions of the SA or any of the Action Steps in the POI. The monitoring team concurs. The facility had made substantial progress since the baseline review. The shell of a Quality Assurance Plan had been developed and many components had become operational as of August, 2010. A format for generating Compliance Reports had been developed and several reports had been produced. The facility had established work groups for each provision of the SA. These workgroups are tasked with developing operational plans to achieve SA compliance, including a QA component for each provision. Many Action Steps in the POI have a target date of 1/30/12. The monitoring team looks forward to further assessment at

	the next review.
	Summary of Monitor's Assessment: DSSLC had established a Quality Assurance/Quality Improvement Council (the Council). The Council takes the place of the Performance Improvement Committee. The Council's work is intended to "assure effective coordination of all facility functions and sufficient information about functional outputs and outcomes to allow facility leadership to have ongoing active knowledge of the facility's ability to consistently comply with regulatory requirements, settlement agreement compliance, and process improvement initiatives throughout the organization." The first meeting of the Council was on 9/23/10. Information, including data, bar, and line graphs was reviewed for sections C, D, E, F, J, K, M, O, P, Q, and R of the Settlement Agreement. DSSLC also had a Trends Analysis Committee in place. These organizational structures are a good foundation for future development and refinement of the QA/QI 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 DSSLC POI reported lack of substantial compliance with this provision and the Action Steps that are included in the POI. The monitoring team concurs. The POI reported a target date of 12/1/10 for implementation of this provision. DADS Policy 003- Quality Enhancement was reviewed and it was consistent with the requirements of the Settlement Agreement (SA). Denton SSLC Policy CMGMT-15 Quality Enhancement Process, dated 1/5/10 guides the Facility's quality assurance processes. Section I-D of the policy describes data collection requirements. The POI reported this policy is under review to ensure it includes all necessary components to comply with DADS policy. The Facility held daily DSSLC Incident Management Review Team (IMRT) and daily unit meetings. Allegations and incidents, restraint, medical issues, and environmental concerns were reviewed at these meetings. These meetings were a good basis for further review and analysis of individual issues and could also serve as an additional point for review of system-wide data. The IMRT provided a forum from which action plans can be developed and tracked. The Trend Analysis for August, 2010 contained data for restraints, unusual incidents, injuries, allegations of abuse, and confirmed abuse. Most data were displayed showing current month and compared that data item to each month over the last few years. Most trend analysis data were broken down further displaying location, shift, and other variables. The data system itself is capable of producing reports isolating very specific variables. For example, if the QA/QI Council wanted to look at injuries on second shift on weekends the data system could produce this type of report. This will be very helpful in	N

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		future quality improvement efforts. DSSLC had established a Quality Assurance/Quality Improvement Council (Quality Council). At DSSLC the Quality Council takes the place of the Performance Improvement Committee. The Council's work is intended to "assure effective coordination of all facility functions and sufficient information about functional outputs and outcomes to allow facility leadership to have ongoing active knowledge of the facility's ability to consistently comply with regulatory requirements, settlement agreement compliance, and process improvement initiatives throughout the organization." The first meeting of the Council was on 9/23/10. Information, including data, bar, and line graphs was reviewed for sections C, D, E, F, J, K, M, O, P, Q, and R of the Settlement Agreement. This structure is an excellent foundation for future development and refinement of the QA/QI process. Most of the data reviewed by the Quality Council comes from the monitoring tools that are used for each provision of the SA. Frequency of use, sample size, and knowledge level of those using the tools is variable. The tools have been developed by different departments at different times so there is a lack of uniformity in appearance and content. The presence and use of tools represent improvement from the baseline visit. There are challenges ahead to refine the tools. For example, most monitoring tools do not include instruction sheets or guidelines that would facilitate consistency between those doing the monitoring. Data items on the tools have not been weighted so in preparing overall compliance reports the most critical data item counts the same as the most mundane. Steps need to be taken to ensure monitors/reviewers who do not have specific subject matter expertise have adequate guidance from someone with specific subject matter expertise. Finally, some of the indicators on a tool may be specifically designed for a team approach to monitoring. For example, some indicators reference gathering information from other team members who have specific expertise. Nevertheless, the work effort to date is a good start and is moving in the right direction.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each	The DSSLC POI reported lack of substantial compliance with this provision and the Action Steps that are included in the POI. The monitoring team concurs. The POI reports a target date of 1/30/12 for implementation of this provision. DSSLC had started a process to analyze data; however, it is very rudimentary. The first meeting of the Quality Council was held several days before the review by the monitoring team. The report generated for review by the Quality Council included narrative summaries along with graphed data for many provisions of the SA. Most narrative merely restated what was obvious from a bar graph comparing July data to August data. For example, for section C Restraints the narrative cited three components on the	N

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	action step; the person(s) responsible; and the time frame in which each action step must occur.	monitoring tool that showed improved performance and three that showed regression month to month. Facility staff acknowledged this was a very preliminary attempt to start getting data organized and to get the Quality Council prepared for the work ahead as SA implementation continues. As more data are input into this process, and as it becomes more reliable, eventually the DSSLC will need to develop methods to analyze these data to understand areas of concern requiring priority corrective action. In addition to the Quality Council DSSLC has a Trends Analysis Committee. This committee met 9/16/10 and its minutes reflect discussion on unusual incidents, abuse/neglect, injuries to consumers, and restraints. The minutes reflect what appears to be thorough discussion with at least some general follow-up activities identified. For example, in the injuries section of the minutes it is noted "two individuals were identified as having a significant number of falls." The Actions column notes "one individual has an increased level of supervision to assist in reducing falls when possible. Both of the individuals' PSTs have met about individual plans and actions…" The minutes identify a person responsible and a due date. The last section of the minutes includes a status update on recommendations from the previous month/quarter indicating this committee tracks, at least, the issues coming to its attention. The facility IMRT is another forum where follow-up actions are tracked. Entries on the minutes of this group typically remain on subsequent agendas until the group determines follow-up has occurred and the issue has reached a point of resolution. Disciplines have begun to develop improvement projects. For example, Facility level reviews of medication practices that relate to polypharmacy were conducted by the Pharmacy and Therapeutics Committee (P&TC). Two such reviews were conducted during the review period. Benztropine use at DSSLC was reviewed in April, 2010, and clonazepam use at DSSLC was reviewed in July, 2010. These reviews were detailed and substantive. It will be important for the Facility to include information about such reviews in its overall QA plan and documentation. All the efforts presently in place at DSSLC that track issues to their resolution need to be identified and made part of one comprehensive system that enables leadership easily to access performance reports. For the Facility to be in compliance with this provision, a system will need to be in place that identifies many components of protections, supports, and services. In addition to collecting and reviewing monitoring data, making certain those data are reliable, and tracking corrective actions, the Facility will need to develop key indicators and outcome measures. Simple analysis that "we're trending up" or "we're trending down" is not	

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		sufficient. Key indicators and outcome measures will enable the Facility to proactively identify homes, day/vocational programs, and/or departments that require improvement, as well as identify an array of potential systemic issues requiring attention.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	The DSSLC POI reported lack of substantial compliance with this provision and the Action Steps that are included in the POI. The monitoring team concurs. The POI reports a target date of 1/30/12 for implementation of this provision. Each provision of the SA has a work group established which initiates activity and monitors compliance implementation and progress for their respective provision. The POI reports that the chairperson of each work group will be expected to ensure this provision is met. Other than issues that are part of the regular IMRT meetings the monitoring team did not identify any formal and comprehensive system, of corrective action planning during this review.	N
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.	Refer to E.2 and E.3.	N
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	Refer to E.2 and E.3.	N

Recommendations:

1. Continue efforts to develop the quality assurance plan, including beginning the conversation of key indicators and outcomes.
2. Refine the monitoring tools to be more uniform in appearance and content.
3. Identify content experts for each tool who can validate that DSSLC auditors/monitors using each tool have sufficient knowledge from which to assess data items on each tool.
4. Develop instruction sheets and guidelines for each monitoring tool.
5. Develop a system of "weighting" data items on monitoring tools, where appropriate.
6. Develop key indicators and outcome measures to proactively identify homes, day/vocational programs, and/or departments that require improvement, as well as identify an array of potential systemic issues requiring attention.
7. Develop and define a system of corrective action planning that builds on work already underway.

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:** **Documents Reviewed:** 1. DSSLC Plan of Improvement 5/17/10 2. DSSLC Supplemental Plan of Improvement 7/6/2010 3. DADS Policy 004 Personal Support Plan Process 7/30/10 4. DSSLC Policy Client Management-12 – Development, Monitoring, and Revision of Individual Habilitation Plans 5. PSPs for Individuals #489, #581, #319, #65, #290, #629, #110, #495, #342, #776, #743, #387, #309, #211, #571, #326, #390, #289, #457, #741, #11, #129, #670, #478, and #392.. 6. PSP Monitoring Checklist for individuals #489 (9/7/10), 619 (9/7/10), and #33 (9/23/10). 7. PNMT evaluation with Positive Behavior Support Committee (PBSC) input for individual #756 (9/16/10). 8. PALS Assessment Summary for individual #290, 8/31/10. 9. PSP signature sheets for individuals #703, #632, #478, #319, #290, and #629. 10. Community Living Options Information Process Worksheet for individual #629, 6/24/10. **People Interviewed:** 1. Rebecca Wilkins, Director of Quality Assurance 2. Frank Padia, Director of Program Coordination 3. Randy Spence, Director of Behavioral Services 4. Elaine Davis. Director of Training and Development 5. Dora Tillis, Assistant Director of Programs 6. Lori Powell, SA Coordinator **Meeting Attended/Observations:** 1. Incident Management Team 3/29/10. 2. Annual PSPs for Individual #209, #327, #568, and #772 3. Critical Incident team meeting 9/30/10. 4. Timberhill morning unit meeting 9/29/10 5. Staff training session on new PSP process 9/29/10 6. Training on individual programs by psychologist to DCP at 508C on 9/30/10
	Facility Self-Assessment:: The DSSLC POI reported it was not in substantial compliance with any of the provisions of the SA or any of the Action Steps in the POI. The monitoring team concurs. DADS issued new policy direction on PSP development on 7/30/10. The training curriculum accompanying this new policy is entitled "Supporting Visions" and is intended to reinforce the fact planning is to support the individuals' vision for the future for him/herself. DSSLC received training on the new policy in August, 2010. DSSLC began training its staff on 8/23/10. The new PSP format, and process, was implemented at DSSLC on September 1, 2010.

	Most target dates for Action Steps in this provision are either 3/26/11 or 6/26/11. The Facility reported the new PSP process started 9/1/10. Training is still occurring. The monitoring team attended a training session.
	Summary of Monitor's Assessment: DADS issued new policy direction on PSP development on 7/30/10. DSSLC received training on the new policy in August, 2010. DSSLC began training its staff on 8/23/10. The new PSP format and process was implemented at DSSLC on September 1, 2010. At the time of implementation, and at the time of the monitoring visit, not all staff had received initial training on the new process. The monitoring team had an opportunity to observe a staff training session on 9/29/10 attended primarily by nurses. The DADS policy is being implemented without the benefit of a DSSLC specific policy. The target date set by the DSSLC for a local policy is 12/1/10. The monitoring team reviewed all PSPs developed using the new process and attended four PSP meetings during the week of the review. Staff involved in the new process were, for the most part, enthusiastic and embraced the new process as it focuses on the individuals' vision for the future and his/her strengths and aspirations. Meetings were observably more interesting than those attended during the baseline review. As one might expect when a change this significant is initiated, initial implementation will have (and did have) mixed results. Discussion focused on the individual and many attempts were made to draw the individual into the conversation. Staff did their best to follow the new process but the meetings did not flow smoothly. Staff were struggling to adapt to this different way of conducting a PSP meeting. This is not surprising as a change this significant can be expected to take time to assimilate into the culture of the organization. DSSLC had a monitor/reviewer in each meeting who took notes and immediately debriefed the team after the meeting. DSSLC is to be commended for embracing the new process but it is clear considerable work lies ahead for effective implementation.

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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 DSSLC POI reported lack of compliance with all Action Steps related to all components of this provision. The monitoring team concurs. DADS issued new policy direction on PSP development on 7/30/10. DSSLC received training on the new policy in August, 2010. DSSLC began training its staff on 8/23/10. The new PSP format, and process, was implemented at DSSLC on September 1, 2010.	N
F1a	Be facilitated by one person from the team who shall ensure that	The DSSLC POI reported lack of compliance with this Action Step. The monitoring team concurs.	N

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	members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	From PSP meetings attended, and PSP documents reviewed it is clear the PSP meetings were facilitated by one person. The new process shows preliminary evidence of greater participation by team members in preparation of and during the PSP meeting. Although participation by PST members during the annual PSP planning meeting was much improved, there is limited evidence that the interdisciplinary team process (outside the team meeting and preparation) had resulted in an increased level of participation by all team members.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	The DSSLC POI reported lack of compliance with this Action Step. The monitoring team concurs. In the POI the facility established a target date for compliance with this Action Step of 6/26/11. PSP meetings attended by the monitoring team were generally well attended by PST members. There is a concern that there is not sufficient direct care professional (DCP) input and participation in the process. DCPs are usually the "staff who regularly and directly provide services and supports to the individual" on a daily basis." Ordinarily only one DCP is present. DSSLC should give consideration to requiring two DCPs to be at a PSP meeting, representing two shifts. This can be particularly important if some of the issues an individual has occur on second shift, or, if the person is routinely awake for extended periods most nights. An additional concern is the lack of speech/language input and participation. The SLP is not actively participating because of resource issues (lack of SLPs). Many individuals with identified speech needs did not have an SLP as a participant in their PSP meeting, including, #495, #342, #776, #743, #387, #309, #211, #571, #326, #390, #289, #457, #741, #11, #129, #670, #478, and #392.	N
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.	The DSSLC POI reported lack of compliance with this Action Step. The monitoring team concurs. In the POI the facility established a target date for compliance with this Action Step of 6/26/11. There are multiple examples of circumstances changing in a person's life that should result in a review and possible change in status. Individual examples of where the PNM (NMT) team did not meet regularly to address change in status, assessment, clinical data and monitoring results included:	N

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		• Individual #342 developed aspiration pneumonia twice. There was no evidence that the PNM (NMT) met to discuss issues. There also was no evidence that the PST met to discuss the aspiration post hospitalization. • Individual #387 developed aspiration pneumonia. There was no evidence that the PNM (NMT) met to discuss issues until the regularly scheduled meeting on 4/23/10. The PST did meet post hospitalization but there was no evidence of discussion of the aspiration event. • Individual #743 developed aspiration pneumonia. There was no evidence that the PNM (NMT) met to discuss issues until the regularly scheduled meeting a month later. The PST did meet post hospitalization but there was no evidence of discussion of the aspiration event. • Individual #309 developed aspiration pneumonia twice. There was no evidence that the PNM (NMT) met to discuss issues. The PST did meet post hospitalization but there was no evidence of discussion of the aspiration event. • Individuals #526, #255, and #90 all have BMIs greater than 40. The dietician recommended increased exercise but there was no evidence this recommendation was integrated into the overall plan of care.	
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 DSSLC POI reported lack of compliance with this Action Step. The monitoring team concurs. In the POI the facility established a target date for compliance with this Action Step of 3/26/11. Although the PSP planning process showed some improvement, the PSPs developed during meetings held during the visit were not scheduled to be completed in time for review. PSPs to this point did not clearly document all actions in one place. For example, Action Plans for services and for learning objectives were not in the same place as PBSP objectives.	N
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	The DSSLC POI reported lack of compliance with this Action Step. The monitoring team concurs. In the POI the facility established a target date for compliance with this Action Step of 6/26/11. Although DSSLC had recently implemented the new statewide PSP process that was designed to make the identification of supports and services, in any setting, more person-centered, the process as observed focused on immediate preferences rather than on supports needed for community living. Discussion of community living options and obstacles thereto were minimally addressed in the observed PSPs.	N
F2	**Integrated ISPs -** Each Facility	The DSSLC POI reported lack of compliance with all Action Steps related to all	N

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	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:	components of this provision. The monitoring team concurs. DADS issued new policy direction on PSP development on 7/30/10. DSSLC received training on the new policy in August, 2010. DSSLC began training its staff on 8/23/10. The new PSP format, and process, was implemented at DSSLC on September 1, 2010. The new process for PSP planning is intended to move SSLC's to an integrated PSP that would meet the components of this provision of the SA.	
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:	PSPs have been developed for each individual. As noted below, they do not meet all the requirements of this provision.	N
	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;	The DSSLC POI reported lack of compliance with this Action Step. The monitoring team concurs. In the POI the facility established a target date for compliance with this Action Step of 6/26/11. DSSLC had recently implemented the new statewide PSP process that was designed to make the identification of supports and services, in any setting, more person-centered. Training in this new Supporting Visions curriculum had been ongoing at the Facility since 8/23/10. According to the Report to Monitors provided at the entrance meeting, 377 staff had been trained in the new process. It remains to be seen whether this new process will result in any enhancement to the ability of PSTs to assess the supports and services needed by individuals in the most integrated setting. The new process did appear to succeed in focusing the PST on preferences of the individuals and how action plans might be developed to support those preferences. The PSTs made attempts to address this component but they were for the most part superficial and did not relate to the individuals prioritized needs; instead, PSTs had a tendency to focus on food and activity preferences and did not lead to prioritizing supports or overcoming barriers to community living. • For example, for Individual #562, much of the emphasis of the meeting centered on the individual's preferences for Pepsi. During the same meeting, the individual expressed a desire to move to a community setting. In the face of opposition from his LAR, the PST did not pursue this interest. The PST seemed comfortable addressing the desire or Pepsi, but did not seem to know how it might examine this stated interest to understand what the individual might find attractive about a community setting, and how the team could build on those lifestyle interests.	N

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		• In the same vein, for Individual #705, the PST focused on certain preferred activities, but failed to grasp the perhaps larger significance of the individual's preference for small group and 1:1 attention, including how this might impact the individual's experience of social relationships and how a living environment might need to be structured. With that said, the two PSPs attended still seemed likely to result in more focus on an individual's preferences, and could serve as a basis for developing a fuller vision of a desired life. The PST members and families who attended seemed energized by the focus and were creative in their approaches to addressing the identified preferences. Encouraging community participation was usually well addressed; however, it was usually addressed in the context of a person doing something in the community rather than community participation There are differences between going to the community to do something but not participating with community members (e.g., going to a movie or restaurant where the staff pay and people sit together), participating in community activities (e.g., going to a volunteer event where the individuals participate alongside community members or participating in an activity with a service club), learning from the activity, which might be integrated with community members or not (e.g., using personal money to make purchases in stores or restaurants as part of an Action Plan with a goal, working at a community worksite such as the UNT dish room), and using all those opportunities to assist in overcoming selected barriers to community living.	
	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;	The DSSLC POI reported lack of compliance with this Action Step. The monitoring team concurs. In the POI the facility established a target date for compliance with this Action Step of 6/26/11. The PSPs reviewed, and PSP meetings observed by the monitoring team usually had measurable goals/objectives but it was difficult relating them to personal preferences or determining if they were directed towards overcoming a barrier to living in the most integrated setting appropriate to the individual. For example, during the PSP meeting for Individual #152, goals were not developed that could build on the individual's interest in community living. While recognizing that the LAR opposed such a move, the monitoring team would still look to see whether the PSP included opportunities to learn skills that might overcome obstacles to community living.	N
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for	The DSSLC POI reported lack of compliance with this Action Step. The monitoring team concurs. In the POI the facility established a target date for compliance with this Action Step of 6/26/11. There was little evidence of integrated protections, services and supports, treatment	N

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	the individual;	plans, clinical care plans, and other interventions observed by the monitoring team in record review and meeting observation. For example, Individuals #526, #255, and #90 all have BMIs greater than 40. The dietician recommended increased exercise but there was no evidence this recommendation was integrated into the overall plan of care. DSSLC will be initiating a monitoring effort targeting integrated planning to identify issues to present to facility leadership. It was reported this will initially consist of reviewing 20 PSPs per month.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	The DSSLC POI reported lack of compliance with this Action Step. The monitoring team concurs. In the POI the facility established a target date for compliance with this Action Step of 6/26/11. The new format for the PSP organizes this information in a clear and understandable manner including column headings for measurable steps, implementation date, person responsible, where it occurs, who will monitor, how often to monitor, where to document, and completion date. Because the format is very new and there were few PSPs yet developed, this will need to be reviewed for compliance at the next compliance visit.	N
	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	The DSSLC POI reported lack of compliance with this Action Step. The monitoring team concurs. In the POI the facility established a target date for compliance with this Action Step of 6/26/11. The PSPs developed under the new system have not as yet improved the development of services and supports that are practical and functional, as the new process has just begun, and PSPs developed using this process are just being implemented. The monitoring team will evaluate the results of the new PSP process at the next compliance review.	N
	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	The DSSLC POI reported lack of compliance with this Action Step. The monitoring team concurs. In the POI the facility established a target date for compliance with this Action Step of 6/26/11. The new format for the PSP organizes this information in a clear and understandable manner including column headings for measurable steps, implementation date, person responsible, where it occurs, who will monitor, how often to monitor, where to document, and completion date. As the new process has just begun, and PSPs developed	N

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	person(s) responsible for the data collection, and the person(s) responsible for the data review.	using this process are just being implemented, the monitoring team did not have the opportunity to review the PSPs to see whether this information was identified. However, there were numerous examples of data not being collected or not collected frequently enough. For example: • Considerable deficits were noted in the collection of behavior data, as noted in Provision K4.	
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.	The DSSLC POI reported lack of compliance with this Action Step. The monitoring team concurs. In the POI the facility established a target date for compliance with this Action Step of 6/26/11. The Supporting Visions training attended by the monitoring team emphasized coordination of effort by all team members and that each member has something of value to contribute to every other member, regardless of professional discipline or job classification. The new process has not been in place long enough to measure any observable difference in coordinated goals, objectives, outcomes, services, supports, and treatments.	N
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	The DSSLC POI reported lack of compliance with this Action Step. The monitoring team concurs. In the POI the facility established a target date for compliance with this Action Step of 6/26/11. DSSLC reported in the POI that copies of PSP's are kept in data books for staff to have easy access. The Individual Notebook component (the data books that many staff refer to for PSPs) was still in flux, with several options including group books and "risk info cards" being used. It was reported that record review monitoring will include staff interviews to identify any problems with accessibility.	N
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	The DSSLC POI reported lack of compliance with this Action Step. The monitoring team concurs. In the POI the facility established a target date for compliance with this Action Step of 6/26/11. Generally a monthly review occurs associated with the PSP plan and the individual's progress (or lack thereof), and any emerging issues. There were numerous issues with measuring progress, measuring the efficacy of interventions, and making appropriate responses in the PSP. Refer to sections J, K, L, M, and S..	N

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	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.		
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	The DSSLC POI reported lack of compliance with this Action Step. The monitoring team concurs. In the POI the facility established a target date for compliance with this Action Step of 12/26/11. The POI reported competency based training began on 8/23/10 for the new PSP process – Supporting Visions. The monitoring team does not believe the training observed for nurses on 9/29/10 (a four hour session) was sufficiently detailed to equip clinical staff to fully participate in an integrated planning and service delivery system and did not assess competency to do so. Based on interviews with trainers, the focus was on bringing people on board with a new approach and a new culture rather than providing skills. The QMRPs received an additional four hours of training on leading PSP planning using the new approach. The monitoring team was not able to ascertain the method the DSSLC uses to train DCPs on the implementation of a specific individual's program. Training observed at 508C on 9/30/10 included components of competency-based training, specifically clear instructions of steps in implementing a program, a rationale for the specific interventions, and (for some aspects of the intervention) demonstration. It did not include any requirement for the trainee to answer questions or demonstrate competence at implementing any steps of the intervention being trained.	N
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	The DSSLC POI reported lack of compliance with this Action Step. The monitoring team concurs. In the POI the facility established a target date for compliance with this Action Step of 3/26/11. The monitoring team determined part of this component to be in substantial compliance.	N

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	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.	The facility had one new admission since the baseline review. Individual #110 was admitted on 4/27/10. The PSP was completed on 5/24/10 and at least some parts of the PSP were put into effect immediately. Record review indicated the PNMP was put into effect on 5/24/10. 100% of PSPs reviewed indicated the PSP meeting occurred within one year of the prior meeting. Additionally, the facility had a computerized tracking system to assure PSP meetings were scheduled well within a one year window. Most PSP meetings were scheduled with about a three week leeway in case the meeting needed to be rescheduled due to family or individual schedule conflicts. Two PSP meetings were rescheduled during the visit due to family request. To achieve substantial compliance the facility needs to establish a tracking system to validate when a PSP is put into effect. Related to this is the need to provide an operational definition of what must occur in order for a PSP to be considered "put into effect."	
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.	The DSSLC POI reported lack of compliance with this Action Step. The monitoring team concurs. In the POI the facility established a target date for compliance with this Action Step of 6/26/11. Beginning with the Supporting Visions PSP process, implemented 9/1/10, most PSP meetings are monitored by the QMRP Educator or QA staff. In addition to recording data which can be used to generate compliance reports (refer to section E) the person monitoring the meeting provides immediate feedback to the team after the meeting. Over time this is expected to lead to improved PSP meetings, and, improved PSPs. Tracking and trending of information from this monitoring had not yet begun so there was not yet planning for any systemic improvement actions other than to continue the training until all staff have been trained.	N

Recommendations:

1. Continue to implement the new DADS policy on PSP planning.
2. Develop a DSSLC specific policy on PSP Planning.
3. Ensure competency-based training in the new planning process.
4. Irrespective of the new PSP process, develop mechanisms to ensure individuals are assessed/reassessed in response to changed status or lack of progress in PSP goals/outcomes.
5. Begin to track and trend information gathered from monitoring of PSP meetings.

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Plan of Improvement (POI) 5/17/10 2. DSSLC Supplemental Plan of Improvement (SPOI) 7/6/10 3. Active Record for Individuals #32, #346, #381, #526, #586, #711, and #776 4. DADS Policy 004 Personal Support Plan Process 7/30/10 5. DSSLC Policy Client Management-12 – Development, Monitoring, and Revision of Individual Habilitation Plans 6. PSP Meeting/Documentation Monitoring Checklists for PSP meetings for Individuals #33, #489, and #619 monitored by DSSLC staff 7. PST Signature Sheet for PSP meeting for Individual #599 9/28/10 **People Interviewed:** 1. Interviews with various discipline staff by the members of the monitoring team, as identified in other sections of this report. **Meeting Attended/Observations:** 1. PSP meeting for Individual #599 9/28/10 2. PSP Training Session 9/29/10
	Facility Self-Assessment: The Facility reported that was not yet in compliance with any Action Steps except for collaboration on some issues between the pharmacist and physician (further described, with monitoring team finding, in Section N). Several actions have started, and planning for greater integration of services is occurring. DSSLC reported that there is a work group for long-term planning for integrated clinical services. The monitoring team supports this long-term planning process, as development of integrated planning will involve changes in many aspects of the operation of the Facility. The Facility reported that more clinicians are now expected to participate in the PSP planning meetings. This was evident in observations of PSP meetings. The Facility reported that nurses are to notify Primary Care Physicians (PCPs) of medication side effects noted but that this was not yet in compliance. As reported in Section L, the monitoring team concurs with the Facility's finding.
	Summary of Monitor's Assessment: Although neither provision of this Section was yet in compliance, the monitoring team found encouraging progress. There was effort to develop integrated planning in the PSP meeting, beginning with attendance by clinicians. The inclusion of the Speech and Language Pathologist (SLP) in the PBSC meetings can bring a

	valuable perspective and improve selection of replacement behaviors. There was not yet a process to involve the PST in review of recommendations by outside clinicians. Actual integration of decision-making was still a work in progress. Coaching and monitoring was in place at the PSP meetings to provide opportunities to improve.

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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.	Progress has been made as processes have been established which may lead toward integrated clinical services. Integrated planning is beginning to occur but is not yet routine. The new PSP process promotes integrated planning but has just begun implementation at DSSLC. Training of staff on the new process is ongoing. The PSP meeting for Individual #599 provided an example of a process that has changed significantly. Attendance included clinicians relevant to the individual's needs and supports. There was substantial participation in discussion of preferences and plans by many members of the PST but not all. Nevertheless, although there was much discussion of preferences and how to support the individual to become involved in preferred community activities, some significant areas of health and other interventions did not have the same level of interdisciplinary involvement. An example in which such discussion occurred involved a diagnosis of diabetes and how that could inhibit healing of injuries. The individual picks skin. This was discussed in terms of the implication of the health condition on healing of skin, and discussion also involved how the PBSP addressed the skin picking behavior. During this discussion, the nutritionist identified sugar-free foods that might be preferred, and the home leader talked about encouraging the individual to select appropriate foods and to eat small amounts of other preferred foods. The same level of interdisciplinary planning was not noted in discussions about use of psychotropic medication and how it could affect both health and the skin-picking behavior. In discussion of training on money management, a goal was selected that was not functional although use of real money was appropriately suggested by the staff who was monitoring the meeting; little discussion ensued, but a change from play money to pictures of real money was made in the program. In a similar vein, the individual indicated interest in moving home; the mother, who is LAR, would rather the individual remain at DSSLC. The PST did not discuss any exploration of other community living alternatives. Following the general PSP meeting, the Health Status Meeting (HST) began. The nurse reported on health indicators and reiterated some of the earlier health discussion. The nurse brought up psychotropic medication that had not been discussed earlier, even in discussion of the PBSP.	N

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		Monitoring of PSP meetings is in place. Three examples of monitoring checklists were provided, one as an example of a good PSP meeting, one as an example of an average meeting, and one as an example of a poor meeting. Ratings on the monitoring sheet differed, as did observation comments. Observation comments on the sheet for the meeting rated poor included corrective actions needed. At this time, there had not yet been meetings at which observers did independent ratings to determine whether the monitoring checklists provided reliable information. There were other examples of progress made. • The PNMT was implemented less than one month prior to the review, so there is currently no process that clearly outlines the responsibilities of that group. Per interview with the Habilitation Director, this was something that would need to be developed. Informally the team had met once independently and once as part of the PBSC to address an issue with swallowing that was considered to be more behavior related. This type of collaboration represents a true interdisciplinary process. The practice of having active collaboration between teams triggers comprehensive problem solving that will assist the teams in developing a more proactive approach to treatment. • For persons receiving behavioral supports or interventions, the Facility had a process designed to identify who would benefit from AAC or speech assistance. Attendance at all Positive Behavior Support Committees by an SLP had begun, and an SLP provided consultations to those individuals identified as having speech or language issues that may be contributing to the target behavior. There were other indications that integrated planning was not fully in place. • The SLP was not actively participating in the individuals' PST secondary to lack of staff availability. Examples of individuals with identified speech needs who did not have a SLP participate as a participant in the PST meetings include: Individuals #495, #342, #776, #743, #387,#309, #211, #571, #326, #390, #289, #457, #741, #11, #129, #670, #478, #392. • In 16 of 16 records reviewed (100%) PNMPs were incorporated into the relevant sections of individual Personal Support Plans, but the PNMPs did not contain information regarding oral care and medication administration, nor were there signs of integration across disciplines. As a result of the lack of integration in planning, individuals may not have received the most effective services that might be available. For example, the monitoring team reviewed some cases where psychiatry was not involved in the individuals' care, but might have contributed. • Iindividual #381 came to the attention of the monitors due to high frequency of	

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		use of mechanical restraints. The individual was diagnosed with a developmental syndrome known to be associated with self injurious behavior (SIB). The individual had no psychiatric diagnosis, and review of records over the past 15 years revealed no past involvement by psychiatry. Psychiatric treatment and pharmacotherapy are not necessarily components of treatment of the syndrome or associated SIB, but psychiatric assessment could identify whether pharmacotherapy or other psychiatric services could contribute to the treatment plan and PSP. • As an example of progress in integrated planning, for Individual #172, the psychiatrist demonstrated the complexities of overlapping behavioral and psychiatric treatments. In this case the symptoms of attention deficit disorder were classic, and were properly treated with psychotropic medication. Symptoms of aggression, stealing and self injury were identified as better addressed with behavioral rather than medication treatment, although those symptoms could also have been the basis for the DSM diagnosis of conduct disorder.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	Recommendations were generally reviewed and signed or initialed. PST documentation did not generally reflect reasoning for choosing to adopt or reject recommendations.	N

Recommendations:

1. Continue the development and implementation of the revised PSP process with coaching and monitoring to promote interdisciplinary planning and decisions.
2. Ensure that all policies regarding treatment planning reflect the need for integration across disciplines.
3. Establish a process and guidelines for referral of recommendations from non-Facility clinicians to the PST.
4. Develop and implement policy and procedures for review and decisions regarding recommendations from non-Facility clinicians.

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Plan of Improvement (POI) 5/17/10 2. DSSLC Supplemental Plan of Improvement (SPOI) 7/6/10 3. Active Record for Individuals #32, #346, #381, #526, #586, #711, and #776 4. DADS Policy 004 Personal Support Plan Process 7/30/10 5. DSSLC Policy Client Management-12 – Development, Monitoring, and Revision of Individual Habilitation Plans 6. PSP Meeting/Documentation Monitoring Checklists for PSP meetings for Individuals #33, #489, and #619 monitored by DSSLC staff 7. PST Signature Sheet for PSP meeting for Individual #599 9/28/10 **People Interviewed:** 1. Interviews with various discipline staff by the members of the monitoring team, as identified in other sections of this report. **Meeting Attended/Observations:** 1. PSP meeting for Individual #599 9/28/10 2. PSP Training Session 9/29/10
	Facility Self-Assessment: The Facility reported it no Action Steps for the Section were in compliance. The Facility reported, and the monitoring team confirmed, that a broader range of PST members now attends the Psychiatric Medication Review (PMR) and that the PMR also serves as the quarterly PST review. Several Action Steps related to improved documentation but did not give any additional information on what the focus of these improvements will be. The Facility reported a plan to provide early recognition and reporting of respiratory infection. Based on current outcomes such as frequency of pneumonia, the monitoring team finds this to be a positive step. The Facility reported that a process will be developed to ensure treatments and interventions are modified in response to clinical indicators. The monitoring team finds this to be an appropriate Action Step, but the step must include identifying clinical indicators as well as procedures to report them and policies about timeliness of response.
	Summary of Monitor's Assessment: There were signs of progress on completing scheduled assessments and establishing an interdisciplinary process that may lead to recognition of changes in health and behavioral status that need timely response. Changes in status were not always recognized and reported, discussion awaited scheduled meetings, and

	there were not thorough assessments when there was decline in function. Use of clinical indicators for review of progress was variable, which might be one reason why changes in status did not lead to action.

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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.	Assessments, including nursing and other discipline assessments, and MOSES and DISCUS side effects assessments, were performed as scheduled. Psychology assessments were not done regularly, as identified in Section K. Assessments were not always thorough, complete, and accurate. For example: • In none of the 11 Psychological Assessments was there documentation to support that the information contained in the Assessment was current, accurate and relevant to the understanding of the individual's strengths and needs. Intellectual and adaptive assessments were not current. • The Nursing Assessments of Annual and Quarterly Nursing Assessment as well as the Assessment Section of the Positive Support Plans (PSPs) for these 20 individuals showed progressive improvement since the baseline review. However, they were not complete. For example, Section XI Nursing Summary failed to provide an adequate assessment of individual #214's health status related to each of the HMPs or their effectiveness. There was no comparison of health issues identified between quarters to assess if health status was improving maintaining or regressing. Assessments were not routinely done when changes in an individual's status were noted. • Functional assessments meeting current standards were not included in PBSPs or other psychological evaluation information. • Medication side effects were not identified and reported to PCPs, nor were MOSES and DISCUS assessments done in between scheduled times if the possibility of side effects was noted. • Individual examples of where the PNM (NMT) Team did not meet regularly to address change in status, assessment, clinical data and monitoring results included: o Individual #342 developed aspiration pneumonia on 4/24/2010 and 7/11/2010 but there was no evidence that the PNM (NMT) met to discuss issues. There was also no evidence that the PST met to discuss the aspiration post hospitalization. o Individual # 387 developed aspiration pneumonia on 4/6/2010 but there was no evidence that the PNM (NMT) met to discuss issues until the regularly scheduled 4/23/10 meeting. The PST did meet post hospitalization but there was no evidence of discussion of the aspiration	N

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		event. o Individual #743 developed aspiration pneumonia on 4/16/2010 but there was no evidence that the PNM (NMT) met to discuss issues until the regularly scheduled 5/16/10 meeting. The PST did not meet post hospitalization to discuss the aspiration event. o Individual #309 developed aspiration pneumonia on 6/3/2010 and 7/31/2010 but there was no evidence that the PNM (NMT) met to discuss issues. The PST did meet post hospitalization but there was no evidence of discussion of the aspiration event. o Individuals # 526, #255, and #90 all have BMIs greater than 40. The dietitian recommended increased exercise but there was no evidence that this recommendation was integrated into the overall plan of 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 Related Health Problems.	Diagnoses were consistent with diagnostic criteria. However, individuals showed significant change in status without thorough evaluation to identify possible causes. For example, people who had changed from walking independently to lack of walking and use of wheelchair did not have evaluations of musculoskeletal conditions or health conditions that might cause significant pain. Although this will be rated in compliance for this visit, the next compliance visit will review a large enough sample to determine not only whether diagnoses fit what is identified in assessments and evaluations but also whether assessments and evaluations are adequate to rule out other likely diagnoses.	SC
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.	Treatments and interventions were not always timely or based on adequate assessment. • Functional assessments of behavior did not meet current standards. • The Facility reported that four individuals had been identified as in need of counseling services, but that neither such services nor the policies supporting those services had been implemented. • The PNM (NMT) Team met regularly but did not meet timely to address change in status, assessment, clinical data and monitoring results. • Fourteen out of 16 records reviewed indicated individuals with identified language difficulties were not receiving active Speech Treatment or participating in a Speech program. Examples of Individuals with identified Speech or language difficulties not receiving services: o Individuals #211, #571, #387, and #342 had decreased expressive and receptive speech but there was no evidence of programs in place to address this issue. o Individual #390 had decreased communication. The QMRP stated that	N

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		another assessment would be requested since the last Speech Assessment was conducted in 1992. There was no evidence that this was 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.	Use of clinical indicators of efficacy was variable. The Facility provided no descriptions of clinical pathways or guidance on specific indicators to guide clinicians and PSTs. Numerous examples demonstrated lack of use of clinical indicators of efficacy. • While PNMPs were reviewed at the PSP, there was not a system in place that clearly monitored the effectiveness of the plan by tracking the occurrence or absence of triggers associated with physical and nutritional decline. Many PNMPs had these indicators listed but there was not a method in place that collected this data for review. • There was not a clear system in place that promoted the discussion, analysis and tracking of individual status and occurrence of health indicators associated with physical and nutritional risk. • The monitoring team was concerned about the substantial weaknesses in behavior data. Despite such concerns, there was not any routine assessment of the actual quality of behavior data. Except in isolated cases that were verbally reported, there was no attempt to measure data reliability or interobserver agreement (IOA). Furthermore, when data were graphed to make behavioral changes more visible for timely decisions, , there was no indication on the graph of when the event occurred. Without such indicators, it was very difficult to identify the relationship between behavior, treatment effects and confounding variables. • The process of generating a meaningful medication treatment plan can be more complex than is immediately evident. For example, once the psychiatrist has selected a medication and has identified the desired effects of the medication, the psychologist and psychiatrist must select measures which will be used to evaluate how this will be measured. There was discussion of appropriate clinical indicators for pharmacotherapy and a few good examples but clinical indicators were not yet used routinely and effectively. • Section XI Nursing Summary failed to provide an adequate assessment of individual #214's health status related to each of the HMPs or their effectiveness. There was no comparison of health issues identified between quarters to assess if health status was improving maintaining or regressing. • In the PSP meeting for Individual #599, no data were presented for discussion of progress on the PBSP or health care issues except for report of weight. Other issues were discussed in more vague terms such as "blood pressure is a little up."	N

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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.	A policy/protocol did not exist at the Facility that addressed monitoring of health status and provided clear direction regarding its implementation and action steps to take should issues be noted. Issues related to health status were often not identified as significant and reported for timely action. For example, the monitoring team was concerned that the importance of response to emesis was not recognized. This can result in lack of treatment leading to exacerbation or development of a serious health condition, including the possibility of preventable death. There was not a clear system in place that promoted the discussion, analysis and tracking of individual status and occurrence of health indicators associated with physical and nutritional risk. Based on review of the Facility's monitoring practices, a system was recently put in place to cover mealtime observations; however, this system was implemented the week prior to the review and was not able to be fully assessed at this time. While the system was designed to address mealtime and have multiple professionals involved, a policy or process was not fully developed that included, for physical and nutritional management: o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, o Identification of monitors and their roles and responsibilities, o Monitors are re-validated on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms are correct and consistent among various individuals conducting the monitor, and o Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician.	N
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.	There were numerous examples of treatments and interventions that were not modified in response to clinical indicators. These can be found in many provisions. Furthermore, as indicated in several provisions, use of clinical indicators such as behavioral data, illnesses such as aspiration pneumonia, and signs of difficulty in swallowing did not lead to timely action.	N
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	The new PSP policy and procedures are a step toward implementing clinical services that are integrated among clinical disciplines as well as being part of an overall PSP. Well-defined procedures for monitoring and coaching could enhance and speed up implementation.	N

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	services policies, procedures, and guidelines to implement the provisions of Section H.	No other policies were provided by the Facility that required or promoted implementation of the provisions of this Section. Per report of the Facility, clinical policies and procedures are undergoing revision. As indicated throughout this report, integrated clinical services were not yet routine throughout the Facility, but procedural steps such as joint committee meetings and attendance of clinicians at planning meetings had begun.	

Recommendations:

1. The Facility should continue to improve documentation and should consider having the workgroups identify clinical indicators that should be included in documentation and referred to in assessments and reports.
2. The Facility should complete revision of policies regarding implementation of integrated services and follow these revisions with staff training on the policies and on how to carry out integrated planning.
3. Each discipline should review national standards to identify clinical indicators that could be selected.
4. Treatment plans and PSPs should include information on the clinical indicators to be monitored for specific treatments and interventions.
5. At PSP planning meetings and other treatment review meetings, reference to clinical indicators should be routine as a part of planning interventions, and documentation of decisions should reflect how those decisions were affected by this information.
6. Efforts should be made to ensure staff are attentive to possible side effects of medications as well as to the need for action when health events such as respiratory distress and emesis occur.

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:** **Documents Reviewed:** 1. DSSLC Plan of Improvement 5/17/10. 2. DSSLC Supplemental Plan of Improvement 7/6/2010. 3. Record Reviews of Individuals #495, #342, #776, #743, #387, #309, #211, #571, #326, #390, #289, #457, #741, #11, #129, #670, #478, and #392. 4. DADS Policy Draft (undated) 006 – Risk Management. 5. DSSLC Policy CMGMT -14 At Risk Individuals 11/15/09 6. DSSLC Risk Assessment Tools and Criteria 8/31/09). 7. List of Health Risk Ratings for each risk factor/individual 9/6/10. 8. List of Top 10 aggressive individuals causing injury to peers. 9. List of Top 10 injured individuals. 10. List of individuals supported with bedrails 11. List of individuals injured from bedrails **People Interviewed:** 1. Donna Jessee, DADS Director of Operations, SSLC's 2. Nancy Condon, DSSLC Facility Director 3. Lori Powell, SA Coordinator 4. Dora Tillis, Assistant Director of Programs 5. Donna Groves, OTR, Director of Habilitation Services 6. Joy Sibley SLP, Director of Communication Therapy 7. Rebecca Wilkins, Director of Quality Assurance 8. Deb Salsman, Director of Incident Management 9. Randy Spence, M.S., Director of Behavioral Services 10. Elaine Davis, Director of Training and Development **Meetings Attended/Observations:** 1. Incident Management Team 3/29/10. 2. Annual PSPs for Individual # 327, #568, and #772 3. Critical Incident team meeting 9/30/10. 4. Timberhill morning unit meeting 9/29/10 5. Staff training session on new PSP process 9/29/10
	Facility Self-Assessment: The DSSLC POI reported it was not in substantial compliance with any of the provisions of the SA or any of the Action Steps in the POI. The monitoring team concurs. DSSLC was engaged in trying a new system for assessing risk of individuals living at the facility. This trial

	began 9/1/10 and had not been in place long enough to produce data for the monitoring team to review. DADS was reviewing a draft new policy on At Risk individuals. This draft incorporated many of the elements DSSLC had developed for its trial. In addition DADS is piloting a related system at Lubbock and plans to roll this out to the other Centers, beginning with DSSLC. DSSLC is to be commended for its initiative in developing a different approach to the risk assessment process and DADS should also be commended for moving forward in piloting a new system.
	Summary of Monitor's Assessment: At the time of the monitoring review DSSLC was engaged in piloting a new system for assessing risk of individuals living at the facility. This pilot began 9/1/10 and had not been in place long enough to produce data for the monitoring team to review. DADS was reviewing a draft new policy on At Risk individuals. This draft incorporated many of the elements DSSLC had developed for its pilot. The deficiencies in the at risk system described in the baseline report will continue until a new system is developed and implemented. These deficiencies are primarily the lack of objective criteria from which to assess risk which results in high risk individuals, or individuals at high risk in one or more assessment areas, not being rated high risk and, therefore, not likely to receive the intensity, or frequency, of treatment needed to mitigate risk. Some examples are provided in I1 and I2 to illustrate this ongoing problem. DSSLC is to be commended for its initiative in developing a different approach to the risk assessment process. The initial implementation of the pilot developed by the DSSLC was reviewed by the monitoring team and represented a substantial improvement. For the most part objective criteria were articulated for each risk factor that would cause an individual to be placed in one of three risk categories: high, medium, or low. The system also allowed for clinical judgment to substitute, if warranted, to strict adherence to the stated criteria. The criteria need refinement and the monitoring team made several suggestions to the DSSLC leadership. These suggestions were not specific to specific criteria but reflected a more general approach to the subtleties of risk definition, criteria, and interrelatedness between multiple criteria and risk factors.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	DSSLC was engaged in trying a new system for assessing risk of individuals living at the facility. This trial began 9/1/10 and had not been in place long enough to produce data for the monitoring team to review. DADS was reviewing a draft new policy on At Risk individuals. This draft incorporated many of the elements DSSLC had developed for its trial. In addition DADS is piloting a related system at Lubbock and plans to roll this out to the other Centers, beginning with DSSLC. DSSLC is to be commended for its initiative in developing a different approach to the risk assessment process and DADS should also be commended for moving forward in piloting a new system. The deficiencies in the at risk system described in the baseline report will continue until a new system is developed and implemented. These deficiencies are primarily the lack of	N

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		objective criteria from which to assess risk which results in high risk individuals, or individuals at high risk in one or more assessment areas, not being rated high risk and, therefore, not likely to receive the intensity, or frequency, of treatment needed to mitigate risk. Some examples are provided in I1 and I2 to illustrate this ongoing problem. DSSLC is to be commended for its initiative in developing a different approach to the risk assessment process. The initial implementation of the trial of objective risk criteria developed by the DSSLC was reviewed by the monitoring team and represented a substantial improvement. For the most part objective criteria were articulated for each risk factor that would cause an individual to be placed in one of three risk categories: high, medium, or low. The system also allowed for clinical judgment to substitute, if warranted, to strict adherence to the stated criteria. The criteria need refinement and the monitoring team made several suggestions to the DSSLC leadership. These suggestions were not specific to specific criteria but reflected a more general approach to the subtleties of risk definition, criteria, and interrelatedness between multiple criteria and risk factors. Donna Jessee indicated that current plans for implementation of a new at-risk assessment system and policy are likely to include pilot-testing at facilities, beginning with Lubbock and then rolling out to DSSLC. The current At-Risk screening and identification system does not always accurately identify people who are at risk Twelve of 18 records reviewed did not accurately identify individuals who are at increased risk of physical and/or nutritional decline. Examples of individuals not being appropriately identified include: • Individuals #387, #743, #571, #309, #457, #125, #11, #495, and #289 had aspiration pneumonia within five months of this review but none were listed as being at high risk. • Individual #697 had nine falls occurring from 6/16/10 to 9/21/10 but was not listed as being at high risk. • Individual #350 had a BMI of 13.34 and a 14 lb weight loss from 1/10 to 5/10 but was not listed as being in high risk. DSSLC risk screening assessments resulted in 27 individuals identified as high risk for aspiration, 32 for respiratory issues, 27 for GI concerns, 6 for choking, 15 for falls, 50 for weight gain, 20 for weight loss, 27 for skin integrity, 13 for self-injurious behavior, 16 for	

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		constipation, 3 for dehydration, 47 for seizures, 87 for osteoporosis, and 106 for oral hygiene,	
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.	At the time of the monitoring review DSSLC was engaged in piloting a new system for assessing risk of individuals living at the facility. This pilot began 9/1/10 and had not been in place long enough to produce data for the monitoring team to review. DADS was reviewing a draft new policy on At Risk individuals. This draft incorporated many of the elements DSSLC had developed for its pilot. The deficiencies in the at risk system described in the baseline report will continue until a new system is developed and implemented. These deficiencies are primarily the lack of objective criteria from which to assess risk which results in high risk individuals, or individuals at high risk in one or more assessment areas, not being rated high risk and, therefore, not likely to receive the intensity, or frequency, of treatment needed to mitigate risk. Some examples are provided in I1 and I2 to illustrate this ongoing problem. DSSLC is to be commended for its initiative in developing a different approach to the risk assessment process. The initial implementation of the trial of objective risk criteria developed by the DSSLC was reviewed by the monitoring team and represented a substantial improvement. For the most part objective criteria were articulated for each risk factor that would cause an individual to be placed in one of three risk categories: high, medium, or low. The system also allowed for clinical judgment to substitute, if warranted, to strict adherence to the stated criteria. The criteria need refinement and the monitoring team made several suggestions to the DSSLC leadership. These suggestions were not specific to specific criteria but reflected a more general approach to the subtleties of risk definition, criteria, and interrelatedness between multiple criteria The current At-Risk screening and identification system did not always accurately identify people who are at risk . A review of 16 individual records documented that the PNM (NMT) team met regularly but does not meet in a timely manner to address change in status, assessment, address clinical data, and monitoring results. Examples include: • Individual #342 developed aspiration pneumonia twice. There was no evidence that the PNM (NMT) met to discuss issues or to provide new assessment. There also was no evidence that the PST met to discuss the aspiration post	N

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		hospitalization. • Individual #387 developed aspiration pneumonia. There was no evidence that the PNM (NMT) met to discuss issues until the regularly scheduled meeting on more than two weeks later. The PST did meet post hospitalization but there was no evidence of discussion of the aspiration event. • Individual #743 developed aspiration pneumonia. There was no evidence that the PNM (NMT) met to discuss issues until the regularly scheduled meeting on a month later. The PST did meet post hospitalization but there was no evidence of discussion of the aspiration event. • Individual #309 developed aspiration pneumonia twice. There was no evidence that the PNM (NMT) met to discuss issues. The PST did meet post hospitalization but there was no evidence of discussion of the aspiration event. An additional example indicated a health risk that was not identified or assessed: • Individual #298 was observed sitting in his wheel chair with a yellow bandana tied around his head and crossing through his mouth. The bandana was saturated with saliva. Health risks related to the bandana were not identified or assessed. DSSLC risk screening assessments resulted in 27 individuals identified as high risk for aspiration, 32 for respiratory issues, 27 for GI concerns, 6 for choking, 15 for falls, 50 for weight gain, 20 for weight loss, 27 for skin integrity, 13 for self-injurious behavior, 16 for constipation, 3 for dehydration, 47 for seizures, 87 for osteoporosis, and 106 for oral hygiene,	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the	At the time of the monitoring review DSSLC was engaged in piloting a new system for assessing risk of individuals living at the facility. This pilot began 9/1/10 and had not been in place long enough to produce data for the monitoring team to review. DADS was reviewing a draft new policy on At Risk individuals. This draft incorporated many of the elements DSSLC had developed for its pilot. The deficiencies in the at risk system described in the baseline report will continue until a new system is developed and implemented. These deficiencies are primarily the lack of objective criteria from which to assess risk which results in high risk individuals, or individuals at high risk in one or more assessment areas, not being rated high risk and, therefore, not likely to receive the intensity, or frequency, of treatment needed to mitigate risk. Some examples are provided in I1 and I2 to illustrate this ongoing problem. DSSLC is to be commended for its initiative in developing a different approach to the risk assessment process.	N

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	ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	The initial implementation of the pilot developed by the DSSLC was reviewed by the monitoring team and represented a substantial improvement. For the most part objective criteria were articulated for each risk factor that would cause an individual to be placed in one of three risk categories: high, medium, or low. The system also allowed for clinical judgment to substitute, if warranted, to strict adherence to the stated criteria. The criteria need refinement and the monitoring team made several suggestions to the DSSLC leadership. These suggestions were not specific to specific criteria but reflected a more general approach to the subtleties of risk definition, criteria, and interrelatedness between multiple criteria. If risk is not assessed, or not addressed in a timely manner, or not addressed accurately the plans that flow from the risk assessments are inherently flawed. The monitoring team did not identify substantive plans of preventive interventions. A typical intervention for most risks, including many medically oriented risks, was "enhanced supervision." These plans did not identify clinical indicators to be monitored to determine changes in risk level.	

Recommendations:

1. DSSLC should continue refining the risk assessments tools and criteria developed for its pilot.
2. DADS should finalize a new statewide policy on risk assessment. Development of criteria should involve getting recommendations and review from clinicians at the SSLCs and RGSC.
3. Pilot testing should identify needed revisions in draft policy and in the implementation of assessment and procedures for integration into the PSP.
4. Once new statewide policy is finalized DSSLC should develop a policy and related procedures for implementation.

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken To Assure Compliance:** **Documents Reviewed:** 1. Denton Plan of Improvement (POI) 5/17/10 2. Denton Supplemental Plan of Improvement (SPOI) 7/6/10 3. A list of individuals who have received pre-treatment sedation medication for medical or dental procedures since 03-01-2010, that included: date the pre-sedation was administered, and the name dosage, and route of the medication 4. A spreadsheet of individuals who were prescribed psychotropic/psychiatric medication, and for each individual the name of the individual; the residence/home; the diagnoses; and the medication regimen (including psychotropics, nonpsychotropics, and PRNs, including dosage of each medication and times of administration) 5. A list of individuals prescribed benzodiazepines that included the name of medication prescribed and duration of use 6. A list of individuals prescribed anticholinergic medications that included the name of medication prescribed and duration of use 7. A list of individuals prescribed intra-class polypharmacy that included the names of medications prescribed and each medication's start date 8. A list of individuals treated with Reglan who were monitored for tardive dyskinesia 9. A separate list of individuals prescribed each of the following: Anti-epileptic medication used as a psychotropic medication; lithium; tricyclic antidepressants; trazadone; beta blockers being used as a psychotropic medication; Clozaril/clozapine; Mellaril, and Serentil 10. A list of new admissions since January 1, 2010, and whether a Reiss scale was used. For three (3) individuals most recently admitted, and for the six (6) individuals for whom information was provided pursuant to section VIII.13 of this document request (i.e., a total of 9 individuals): Their most recent psychiatric assessment; the last three (3) psychiatric progress review notes, including data provided to the psychiatrist by the psychologist and/or other team members. For the past year: Dates of all Psychiatric Medication Reviews (PMR) and Health Services Team(HST) notes, Moses and Discus exams, Neurology consults; and the most recent Medical, Pharmacy, and Nursing summaries 11. A list of all meetings and rounds that were typically attended by the psychiatrist, and which categories of staff always attend or might attend 12. A list and copy of all forms used by the psychiatrists 13. Examples of forms used to document side effects, e.g., AIMS, MOSES, and DISCUS 14. All policies, protocols, procedures, and guidance that relate to the role of psychiatrists 15. Job description of psychiatrists 16. A list of all psychiatrists, including board status (i.e., board-certified, board-eligible); whether employee or contracted; and (b) number of hours working per week 17. Example of contract with contracted psychiatrists 18. CVs of all psychiatrists, including any special training such as forensics, disabilities, etc.

	19. Overview of psychiatrists' weekly schedule 20. Description of administrative support offered to the psychiatrists (e.g., secretarial, administrative scheduling of psychiatric consultation, etc.) 21. Since January 1, 2010, a list/summary of complaints about psychiatric and medical care made to the facility by any party 22. Over the past 12 months, a list of continuing medical education activities attended by medical and psychi staff. 23. Over the past 12 months, a list of educational lectures and in-service training provided by psychiatrists and medical doctors to facility staff 24. A list of academic affiliations of medical and psychiatric staff 25. A list of library resources available to psychiatrists, including: (a) Online medical literature (e.g., Epocrates, PubMed); and (b) Books, texts, newsletters, journals, international consensus guidelines 26. A list of professional affiliations of psychiatrists and/or facility, including: (a) List of affiliations and linkages with local hospitals and specialists; (b) Status of psychiatrist membership in the American Psychiatric Association and/or Texas medical or psychiatric associations and/or (c) Academic affiliations with educational institutions 27. For the past six months, minutes from the committee that addresses polypharmacy. (a) For the last 10 newly prescribed psychotropic medications, PMR/progress notes documenting the rationale for choosing that medication (b) Signed consent form (c) Positive Behavior Support Plan (PBSP) and Human Rights Committee (HRC) documentation 28. Since January 1, 2010, a list of any individuals for whom the psychiatric diagnoses have been revised 29. Since January 1, 2010, a list of the 10 individuals who had the highest number of injuries 30. Since January 1, 2010 a list of the individuals who caused the most injuries to peers 31. For March and April 2010, DSSLC nursing quality assurance printouts for MOSES/DISCUS monitoring, for psychiatry, for psychological services 32. Benztropine Drug Utilization Evaluation – Pharmacy and Therapeutics Committee (P&TC) meeting, July, 2010 33. Clonazepam Drug Utilization Evaluation – P&TC meeting April, 2010 34. P&TC minutes for the six month preceding the tour of the monitoring team 35. Printout of DSSLC psychiatrists' caseload assignment 36. Clinical records for individuals #704, #018, #799, #399, #606, #258, #335, #494, #686, #342, #199, #287, #449, #557, #587, #172, #488, #605, #250, #349, #578, #306, #35, #108, #289, #472, #562, #540, #490, #258, 127, #540, #14, #490, #229, #381, #337, and #187 **People interviewed:** 1. Zuorong Lin, M.D., Psychiatrist 2. Arifa Salam, M.D., Psychiatrist

	3. Satyajit Satpathy, M.D, Psychiatrist 4. Randi Spence, M.A., Director of Behavioral Services 5. Rosha Chadwick, R.Ph., Pharmacy Director 6. Lori Powell, Settlement Agreement Coordinator (SAC) 7. Brenda Morris, Psychiatry Assistant 8. Devon Wince, Psychiatry Assistant **Meeting Attended/Observations:** 1. Psychiatric Medication Reviews (PMR) by Dr. Salam (09/28/10) 2. PMRs by; Dr Lin (09/28/10) 3. Personal Support Plan (PSP) meetings for individual # 562 (09/29), and individual #187 (09/29)
	Facility Self-Assessment: The Facility reported that all staff psychiatrists and the contract psychiatrist were appropriately trained and qualified. Reiss Screens were completed for all individuals who resided at DSSLC, and psychiatric assessments with diagnoses were in place for all individuals who had psychiatric diagnoses or who received psychiatric medications. The Facility assessed that psychotropic medication use was appropriate and reported that a process was in place for the on-site neurologist and DSSLC psychiatrists to coordinate care. The Facility acknowledged that active problem lists did not include the psychiatric diagnoses, and it reported that a process for pretreatment/sedation would be put in place during the next six months. **Based on interviews with staff and review of documents:** The monitoring team agreed that the Facility was in substantial compliance for Settlement Agreement (SA) provisions that required the psychiatric services were provided by qualified professionals, and that a sufficient number of such professionals were employed by the facility. The monitors agreed that psychotropic medications were not used for prohibited purposes. The monitors found that the requirement for deployment of Reiss Screens had been met, that Facility level reviews to monitor psychotropic use were in place, and that the psychiatrists and neurologists coordinated care.
	Summary of Monitor's Assessment: DSSLC took many positive steps in the six months since the baseline tour. The facility started to use psychiatric assessments as outlined in Appendix B of the SA, and completed Reiss Screen administrations for all individuals living at DSSLC. DSSLC took positive steps to improve the psychiatry participation with the interdisciplinary process. A psychiatrist now attends Behavior Support Review Committee (BSRC) meetings, and psychiatrists now meet periodically with the on-site neurologist. Psychiatrists started to attend the annual PSP meeting of individuals under their care, and quarterly PMR meetings began to serve as the quarterly updates for the PSP. These steps improved the multidisciplinary and interdisciplinary processes, and they contributed in a tangible manner to improved quality of care. During the current tour: • The monitoring team confirmed that DSSLC psychiatric services were provided by qualified individuals, and that staffing levels were sufficient. Accordingly, SA provisions J1 and J5 were found to

	be in substantial compliance. • The monitoring team examined DSSLC psychiatric assessments and diagnostic formulations. All individuals reviewed had a psychiatric assessment in the clinical record, and many of the evaluations were in the format required by the SA. The monitoring team found that most evaluations were conducted in a clinically justifiable manner and resulted in clinically justifiable diagnoses. The evaluations often provided specific psychiatric symptoms/behavioral characteristics that could be the basis for monitoring psychotropic medication treatments. The monitoring team found that some issues remain to be addressed (SA provisions J2 and J6). • The monitoring team found that Reiss screens had been deployed as required. Accordingly, SA provisions J7 was found to be in substantial compliance. • DSSLC has made many improvements to the interdisciplinary process. The monitoring team identified, however, that improvements are needed in the area of the combined assessment and case formulation (SA provisions J8 and J9). • The monitoring team found that PST procedures for discussion and documentation of risks associated with medication treatment were not sufficient (SA provisions J10 and J14). • The monitoring team found that there were good facility level procedures for monitoring psychotropic polypharmacy. Accordingly, provision J11 was found to be in substantial compliance. • The monitoring team recommended the establishment of a facility level review for DISCUS screen results (provision J12). • The monitoring team examined current procedures for monitoring psychotropic medication treatment. DSSLC was in the process of putting in place some improved procedures for tracking psychiatric symptoms, so as to support such monitoring. The process was in its early stages, but was proceeding well (provision J13). • The monitoring team found good coordination of psychiatry and neurology. Accordingly, SA provision J15 was found to be in substantial compliance. • As a general matter, the monitoring team found that the self assessment process for psychiatry was productive, and DSSLC was responsive to comments and recommendations of the monitoring team. Discussions between the monitoring team and Key DSSLC staff during the monitor's tour allowed the process of improvement to proceed smoothly and rapidly.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	No changes in the psychiatric staffing at DSSLC took place since the baseline tour of the monitoring team. At the time of the compliance visit DSLLC employed three full time staff psychiatrists: Drs. Lin, Satpathy and Salam. A fourth psychiatrist, Dr Harden, worked on a part time basis. The curriculum vitae, medical licenses, and specialty board certificates of the psychiatrists were reviewed. Dr. Lin was eligible for board certification in psychiatry by the American Board of Psychiatry and Neurology. Drs. Harden, Salam and Satpathy were board certified by the American Board of Psychiatry and Neurology. Drs. Satpathy and Salam had a decade of experience in psychiatry, and Dr. Harden had	SC

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		several decades of experience in psychiatry. Drs. Harden, Salam, and Satpathy all had considerable experience working with individuals with mental health needs and intellectual disabilities, and Dr. Lin had close to one year's experience working with this population. Drs. Lin, Salam and Satpathy were interviewed during the compliance tour. Dr. Hardin was not interviewed since he was not on site during the tour. The Medical Director's overall supervision of the psychiatrists was reviewed. As detailed under provision J5, all psychiatrists were involved in a variety of departmental activities. Along with other physicians, they participated in medical department activities. At the time of the tour, 252 individuals who lived at DSSLC received some form of psychiatrist support. DSSLC reported that the caseload of each full time psychiatrist was 75 – 80 individuals, and this was verified by a printout of each psychiatrist's caseload. The job descriptions of the psychiatrists included responsibilities for direct psychiatric care of designated individuals. Individuals were seen for psychiatric care as needs arose, and at regularly scheduled PMRs. Such PMRs typically took place on a monthly and quarterly basis. PMR participants included the individual being reviewed, and the individual's psychologist, qualified mental retardation professional (QMRP), nurse case manager, direct support professionals and other members of the PST. In their day-to-day work the psychiatrists received administrative support from three psychiatry assistants - Ms. Brenda Morris, Ms. Devon Wince, and Ms. Judy Patman. The psychiatric assistants provided the psychiatrists with support for clinic scheduling, with tracking of labs and other items needed for medication reviews, with arrangement for monthly and quarterly PMR's, with telephone calls to guardians for consent, and with general administrative support. Since the baseline visit, DSSLC made a number of changes that involved the psychiatrists' interactions with other professionals in the interdisciplinary process. As outlined under provision J5, DSSLC re-designated the quarterly PMR meetings to also serve as the quarterly update of the PSP. Psychiatrists also started to attend annual PSP meetings for individuals under their care, and Dr. Harden started to attend Behavior Support Review Committee (BSRC) meetings. Psychiatrists continued to attend other interdisciplinary processes: They participated in scheduled Health Support Team (HST) meetings that were led by Primary Care Physicians (PCP), they worked closely with members of the Pharmacy Department, and they reviewed Quarterly Drug Regimen Reviews (QDRRs) that were prepared by those pharmacists; they worked closely with nurse case managers and they reviewed the DISCUS and MOSES screenings that had been completed by those nurses. Psychiatrists attended weekly physician staff meetings, they attended monthly polypharmacy meetings, and they participated on a rotating basis as members of the P&TC.	

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		Overall, the monitoring team found that the psychiatric staff at DSSLC consisted of qualified professionals, who participated meaningfully in the DSSLC interdisciplinary process. Accordingly, the monitoring team found DSSLC to be in substantial compliance with this provision. The monitoring team notes that an interview with Dr. Harden has not been possible yet, since he was not on site during either of the first two tours. Since interviews with psychiatrists are included in the monitoring team's expectations for provision J1, the monitoring team would like to have such an interview during the next tour. A telephonic interview can be conducted if necessary, but a personal interview would be better.	
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.	Since the baseline tour of the monitoring team, DSSLC revised several procedures that relate to psychiatric evaluation and diagnosis: For example, DSSLC implemented use of the comprehensive psychiatric assessments that were detailed in Appendix B of the SA. These assessments were based on a format that required detailed psychiatric diagnoses, based on background information, mental status examination, medical information, and family history, amongst other things. DSSLC stated that all individuals who took psychotropic medication had a recent psychiatric evaluation in the clinical record; as outlined under provision J6, the monitoring team confirmed that these evaluations were in place. DSSLC procedures also provided for the diagnosis to be reviewed, and if necessary updated, during monthly and quarterly PMRs. Since the baseline tour, DSSLC had also revised the template that was used by the psychiatrists, for documentation, during PMRs. For example, the quarterly PMRs was revised and updated to contain a section on psychiatric diagnosis. In that section, the psychiatrist indicated whether the current diagnosis should be continued or changed. If changes were needed, the psychiatrist was required to specify any changes in Diagnostic and Statistical Manual (DSM) Axes I, II, and III. The monitor's broad understanding was that in the future, psychiatrists will also provide some form of annual summary of psychiatric care. In preparation for coming tours, the monitors would appreciate being informed if that indeed is the case. SA provision J2 mandated that psychotropic medication would be prescribed only on the basis of clinically justifiable evaluation and diagnosis. To assess the clinical process that was in place at DSSLC, the monitor assigned to psychiatry reviewed the clinical records of 32 individuals who lived at DSSLC. Records were selected in the following manner: Eight records were selected since the individuals (#686, #199, #287, #172, #605, #35, #187, and #562) had clinical meetings during the tour that were attended by the monitor. Eight records were selected, since the individuals (#258, #557, #587, #488, #250, #289, #472, and #258) had newly prescribed psychotropic medications. Eight records were selected since the individuals (#018, #289, #494, #449, #349, #578, #108, and #127) were also reviewed by the monitor assigned to psychology. Three of these	N

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		records were selected (# 494, #108, and #127) since the individuals were newly admitted to DSSLC. Eight records (#704, #799, #399, #606, #342, #306, #540 and #490), were selected on the basis of the psychiatrist assigned to the individuals in question, to assure that at least six clinical records would be reviewed for each psychiatrist. Three individuals listed above were included in two categories. The clinical records that were selected were examined for evidence of a recent psychiatric assessment. Such an assessment was found in the clinical record of each of the individuals. The oldest assessments dated to 2008, and most were completed in 2010. Newer assessments followed the format that was mandated by SA provision J6, and which was outlined in SA Appendix B. All assessments were reviewed in detail. The monitoring team's assessment of the psychiatric evaluations is presented under provision J6, since Appendix B requirements are the focus of that provision. As a general matter, records for all individuals reviewed contained reasonable psychiatric diagnoses. One of the main problems that faced DSSLC was the fact that in the past, medications were often prescribed to treat "target behaviors" such as "aggression," "agitation," or "self injurious behavior," rather than symptoms of an identified psychiatric disorder. During the compliance tour, the monitoring team looked closely at whether the psychiatric evaluations in the clinical records now contained psychiatric symptoms/behavioral characteristics that supported the selected diagnoses. Many did, but some did not, as mentioned under provision J6. The expectations for medication treatment plans were outlined by SA provision J13. The monitoring team explored whether medication treatments for the individuals reviewed were linked to specific symptoms/behavioral characteristics relevant to the disorders diagnosed for each individual. That discussion is included under provision J13. Additional discussion about the appropriate use of psychotropic medication is provided under provision J3. Discussion about risk/risk language in psychotropic medication plans is provided under provisions J10 and J14. Discussion about the way psychotropic medication monitoring took place (at the level of both specific individuals and at the level of the facility as a whole) is provided under provisions J11, J12 and J15. The DSSLC Plan of Improvement for provision J2 contained an action step for the facility, to show that 100% of records reviewed should show that a process of review and improvement is in place to ensure evaluations and diagnoses are carried out in a clinically justifiable manner. The Facility stated "we do not currently have enough data to support compliance at this time." The monitoring team did not identify a process in place. In order to find the Facility in substantial compliance, the monitoring team needs to	

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		understand the process of review and improvement, and to confirm that psychiatric evaluations identify observable symptoms of the selected diagnoses. Should DSSLC psychiatrists determine that the existing evaluation for any individual needs to be updated with such information, the entire evaluation does not need to be redone – the addition/clarification could be made via some form of clinical update (possibly an annual review), which could be used to summarize changes/updates in diagnosis, provide a summary of the individual's response to treatment during the preceding period, and other key matters relevant to psychiatry.	
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.	The initial report of the monitoring team stated that psychotropic medications were not being used at DSSLC in the absence of a treatment plan, for the convenience of staff, or for punishment. During the baseline tour there was no evidence of prohibited use of psychotropic medications. That continued to be the case. Since the initial visit of the monitoring team, DSSLC reported a number of significant improvements in practices and procedures that related to appropriate use of psychotropics. For example: • In the report that followed the baseline tour of DSSLC, the monitoring team recommended that DSSLC should review practices for generating and monitoring psychotropic medication plans. As outlined in the Plan of Improvement (POI) and Supplemental Plan of Improvement (SPOI), DSSLC determined that treatment plans would be developed at the time of the quarterly reviews (PMRs) and annual meetings. • In the report that followed the baseline tour of DSSLC, the monitoring team recommended that DSSLC should consider the use of accepted observer rating tool(s). Such tools could be used as part of the process of clinical assessment and case formulation (SA provision J8), and also to track psychiatric treatments. As outlined in the SPOI, DSSLC selected the DASH II for such use and it was ordered. The monitoring teams agreed that the DASH II is an appropriate tool. It is particularly well suited for use with individuals who live at DSSLC who do not have the ability to self report symptoms. • In discussions that took place at the time of the baseline tour and in the report that followed, the monitoring team emphasized that it is important to separate the tracking of psychiatric symptoms which are the target of psychotropic medication treatment from the tracking of individuals' broader set of behavioral targets, many of which represent learned behaviors. DSSLC revised the forms used for the PMR, so it now contains separate graphic data presentation for two data sets. One of these contained data for psychiatric tracking, and the other contained data for behavioral tracking.	N

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		In discussions that took place during the baseline tour, the monitoring team emphasized the need for psychiatric treatment (including but not limited to psychotropic medication use) to be better integrated with overall PST processes. To do so, DSSLC broadened the scope of the quarterly PMR. At the time of the tour, that meeting served not only as the quarterly PMR, but also as the quarterly updates of the PSP. Also, the contract psychiatrist started to participate in meetings of the Behavior Support Review Committee (BSRC). Previously, although BSRC reviewed programs of many individuals who receive psychiatric care, there was no psychiatric participation in those meetings. The monitoring team noted that in the POI, DSSLC commented that the active problem list did not include psychiatric diagnoses, and the monitoring team agrees with the implied decision to update the problem list. Although there had been much improvement, the lack of thorough psychological and functional assessment led to the development and implementation of Positive Behavior Support Plans (PBSPs) that may have been ineffective, as identified in Provision K9. Furthermore, as noted in Provision K8, there were no psychological services being provided other than PBSPs. Therefore, although psychotropic medication may not have been used as a substitute for a treatment program, it may have been used as a substitute for a treatment program that was likely to be effective. Therefore, this provision is not yet in compliance.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	In the Plan of Improvement (POI) for provision J4, DSSLC stated that a revised process for pre-treatment sedation will be implemented during the next six months. At the request of the monitors, DSSLC provided information on use of pre-treatment sedation for the previous six months: Such information was provided for five individuals. Clinical records for these individuals were reviewed for evidence of practices in place at DSSLC at the time of the monitor's tour. Examination of the clinical records revealed that medication orders and guidelines were written to assure safety of the individuals during the treatment period. For example: Individual # 572 (On specified date) give diazepam 10 mg rectal diazepam • <u>Post op instruction for dental cleaning or restoration with iv sedation</u> o Check vital signs q 15 minutes	SC

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		o Give patient clear liquid diet for the meal following i.v. sedation o Have the patient void o Infirmary will dismiss when the patient is alert and oriented o Rest in home for 24 hour after appointment o Wheelchair with seat belt for ambulation and nurse with 24 hours status post sedation. The PST for this individual also met and discussed the need for sedation and indicated that a desensitization plan was in place, although the details were not specified. For individual #54: (On specified date) give Halcion 0.5 mg • <u>Post op instruction s for dental cleaning with Halcion</u> o Check vs. every 15 minutes o Give patient clear liquids for the meal following the appointment o Have the patient void o Infirmary will dismiss when the patient is alert and oriented • <u>Post op instructions for dental procedures with Halcion</u> o Check vital signs every 15 minutes o Give the patient clear liquid diet for the meal following extraction and advance the patient regular diet unless other orders are written o Have the patient void	

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		o Rest in home for 24 hours after appointment. At the next compliance visit, the monitoring team will review more broadly the availability and effectiveness of treatments and strategies to minimize need for pre-treatment sedation for dental and medical services to ensure that there is compliance with all requirements of this provision.	
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.	DSSLC employed three full time staff psychiatrists and one part-time contract psychiatrist, for a sum of 3.2 full time equivalent positions. The psychiatrists were supported by three staff psychiatry assistants who provided administrative support. Per the POI, the expectation was that each full time psychiatrist would be assigned a caseload of 75-80 individuals. During the tour the monitor reviewed the caseload assignments. The monitor observed the psychiatrists in their daily work, and interviewed three of the psychiatrists about their experience with their overall workload. On the basis of the documents reviewed, the interviews conducted, the meetings attended, and the observations made, the monitoring team found the current level of psychiatric staffing adequate for DSSLC to ensure the provision of the services necessary for implementation of section J of the SA.	SC
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.	DSSLC stated that a psychiatric assessment was in place for each individual. The monitoring team confirmed that this was the case: A psychiatric assessment was located in the clinical records of every individual whose chart was reviewed by the monitor Many of the psychiatric assessments identified observable symptoms that were a basis for the psychiatric diagnoses of the individuals. For example: • Individual #108 was diagnosed with schizoaffective disorder, depressed type, with rule-outs for bipolar disorder and somatoform disorder, and possible personality disorder with cluster B features. The psychiatrist's History of Present Illness section of the evaluation included the following: *"(Individual #108) has a history of recurring depressive episodes, symptoms of which include social isolation, hypersomnia, lack of appetite, and decreased interaction with others. (Individual #108) has a history of at least one suicide attempt at age 15 by drinking weed killer. (Individual #108) has threatened to kill (self) many times, especially when angry. Psychotic symptoms experienced by (individual #108) include delusions about being chased by someone, people looking at and laughing at , (individual #108), somebody listening to (the individual's) conversation, being a leader of a rock band, (the individual's) father killing dogs at home, etc. (Individual #108) has also been noticed to make bizarre or irrational statements and talking to pictures and posters. Even though (the individual) has*	N

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		displayed serious aggression with resultant injury to others and various other kinds of impulsive behaviors, there is no documented history of mania." Diagnostic summary: *"(Individual #108) presents with mild mental retardation and symptoms of psychiatric illness consisting of prominent psychosis and recurring depressive episode. (The individual) has also displayed chronic impulse control, anxiety, somatization, and maladaptive behaviors indicating Cluster B type personality traits. Family history of schizophrenia and hyperbilirubinemia in immediate postnatal period are likely contributing factors for development of mental problems. Head injury in childhood and seizure disorder may also have an impact on affective and regulation and impulse control."* • Individual #605,was diagnosed with bipolar disorder with psychotic features: *"(Individual #605) has had numerous manic episodes during which (the individual) experiences the following symptoms irritability, agitation, aggressive and violent behavior, euphoria, elated behavior, rapid and disjointed speech, illogical and delusional thoughts, high energy levels, verbally disruptive behavior, insomnia and hallucinations . (The individual) has reported seeing people devils and witches in the past. (The individual) has delusions of being pregnant and having children now and then. Even at baseline, when (the individual is) fairly stable, (the individual) displays impulsivity and irritability."* Medication targets identified were for mania, depression, psychosis, insomnia. These complemented the psychological understanding of the symptoms of learned behavior: *"Functional analysis: "most of the PAI and (the individual's) verbal behavior preceding it appears to be socially mediated negative reinforcement with the reinforcement being the removal or attenuation of social stimulation from peers or staff. Behavioral Targets are PAO and escaping; injuries to self and others."* • Individual # 289 was diagnosed with bipolar disorder and pica: *"(The individual's) psychiatric symptomatology has included extreme withdrawal, sleep disturbance, weight loss, depressive behavior (crying, making negative and depressed statements), physical aggression to others (pulling other's hair grabbing*	

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		their clothes, scratching or biting and disruption of [the individual's] environment). (The individual's) emotional state appears euthymic most of the time. (The individual's) demeanor is generally calm and (the individual) occasionally exhibits a sense of humor with familiar people." The psychiatrist summarized that: *"In addition to the symptoms of developmental delays, cognitive/adaptive deficits mood lability, depression, anxiety, (the individual) is diagnosed with bipolar I disorder and with pica."* The psychiatrist then integrated the understanding of the psychiatric symptoms with considerations from other disciplines: *"(The individual's) psychiatric symptoms have no clear discernable function and it hypothesized that the behaviors also represent a manifestation of partial complex seizures. (The individual) also may be attempting to escape from disliked environments that are noisy crowed and hectic. Attention can be a secondary function. Oral stimulation is a clear function related to pica."* • Individual #562 was diagnosed with bipolar disorder, mixed, with psychosis, and was described by the treating psychiatrist in the following fashion: *"(The individual) has also experienced psychotic symptoms including hallucinations, paranoia, and disorganized behavior, especially during a trial to taper medication haloperidol. During (the individual's) manic or hypomanic episodes (the individual) is unable to sleep, is hyperactive becomes loud and combative. The depressive episodes have been characterized by crying spell, isolation and suicidal ideation. (The individual) has one documented episode of suicide attempt by trying to (details of suicide attempt are provided)."* In the case formulation, these symptoms were the basis for the diagnosis of bipolar disorder. Elsewhere, the psychiatrist placed the observations in a broader context, with additional contributions about learned behavior the psychiatrist cites from colleagues in psychology: *"Targets of maladaptive behavior including PAO, AGP VDP SG, all of which have declines except VDP. Currently, episodic mood swings and irritability along with*	

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		impulsive behaviors persist, albeit no evidence of mania or psychosis." • Individual #18 was diagnosed with generalized anxiety disorder, and was described in the following manner: *"(An individual) who has been living at this facility since November 2009. (The individual) was living at a group home prior to the transfer here. (The individual) has a history of episodic mood swings, irritability and anxiety, along with some aggressive behavior, albeit no evidence of overt mania or hypomania. (The individual's) aggression toward self and staff were documented during the episodes of pseudo seizures (the individual) experienced while residing at the group home. There has been no history of major depression or panic attacks or any psychosis. (The individual) is not distracted or hyper vigilant and no evidence of paranoia or any perceptual disturbances. (The individual) is not noted to have any formal thought disorder."* As part of the mental status examination, the psychiatrist clarified that although the symptoms had been present in the past, they were not present at the time of the evaluation. *"The individual) is awake, alert, smiling intermittently, engaging with self, calm aware of his surroundings, minimal verbalization albeit responding appropriately, bright affect, no anxiety of depression, no mood lability, no distraction or hyper vigilance, paranoia/perceptual disturbances, no RIS, poor insight."* The overall psychiatric evaluation provided the basis for the diagnosis of generalized anxiety disorder. The evaluation also provided a link to work of colleagues in psychology, who determined target behaviors of verbally disruptive behavior and physical aggression to others. • Individual #494 was diagnosed with mild mental retardation and paranoid schizophrenia, and the psychiatric evaluation provided the many symptoms that supported the diagnosis. *"The patient reported that (the individual) had been hearing voices since his childhood and sometimes seeing shadows. (The individual) also reported he's paranoid about people after (the individual) ... The patient believed his sister and others were trying to poison (the individual), per past report. The psychiatrist enquired about mood symptoms and was told "I was thinking*	

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		of killing myself when I broke up with my (friend) when I was young," the psychiatrist notes that at the time of the examination the individual denied any kind of delusions and when asked about the past paranoia that (the individual) stated "It has never happened in my real life." The psychiatric evaluation provided details about the numerous admissions to private and public facilities." The mental status examination was: *"The patient is casually dressed with a T-shirt and a blue jean and (the individual) is well groomed. (The individual) is awake, alert and oriented to time, place and person. (The individual's) affect is bright with "good" mood. (The individual) maintains adequate eye contact and is very cooperative during the interview. (The individual's) speech was spontaneous with low volume and to certain degree it's tangential. (The individual) has intact memory and concentration with borderline intellectual functioning. (The individual) currently has no auditory or visual hallucinations. (The individual) denies SI, HI, intent or plan. He admits being paranoid, but denies any kind of delusion. (The individual) shows no psychomotor agitation or retardation activities with normal gait. (The individual's) insight into his mental illness is limited and his judgment is fair to poor."* Since many details about past psychosis were difficult to ascertain and since the mental status examination was largely negative – not surprisingly so since the individual was treated with two antipsychotic medications – it was very useful for the psychiatric evaluation to contain a description of events: *"During the Fall of 2009 (the individual) requested to have (a psychotropic medication) discontinued. This request was followed and consequently (the individual) became floridly psychotic. (The individual) was described as incoherent, with marked grandiose, paranoid, religious and sexualized delusions. Examples of (the individual's) delusional statements include working for the FBI, being the Pope, being married to (a relative), being a Japanese Psychiatrist, and requesting Midol for pain since (the individual) had just given birth. Hygiene diminished as (the individual) refused to take a shower, wash hand(s), and refused to have others touch (the individual). (The individual) would not reportedly respond to attempts at conversation by others however would spontaneously complain to staff about (the individual). … started to defecate upon (self) and would urinate*	

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		in the trash can and …roommate's belongings, as well as soda bottles which (the individual) would consequently hide them around (the) home." The establishment of the core symptoms for this individual set up not only psychiatric tracking for symptoms, but also provided a needed justification for preventative treatment. • Individual # 172 was diagnosed with attention deficit disorder and with conduct disorder. The psychiatrist provided a summary of the psychiatric symptoms and provided an understanding of how those symptoms integrated with learned behaviors: *"(the individual) experienced hypoxia at birth which has been attributed as the cause of...mental retardation. (The individual) has displayed symptom of attention deficit hyperactivity disorder (impulsivity, short attention span, hyperactivity and restlessness) since childhood. Maladaptive behaviors of aggression, stealing and self injurious behavior are functional and will be addressed via positive behavior support plan. Current medications (named in source document) have been helpful have been helpful in improving symptoms of ADHD and insomnia respectively and they will be continued. (The individual) is tolerating them well and will be monitored closely for improvement or side effects."* Among other things, the psychiatrist demonstrated the complexities of overlapping behavioral and psychiatric treatments. In this case the symptoms of attention deficit disorder were classic, and were properly treated with psychotropic medication. Symptoms of aggression, stealing and self injury were identified as better addressed with behavioral rather than medication treatment, although those symptoms could also have been the basis for the DSM diagnosis of conduct disorder. • Individual #35 was diagnosed with both autism and obsessive compulsive disorder. Although repetitive behaviors are common in the setting of autism, the psychiatrist clarified the reason that both diagnoses were used. *"(The individual) displays symptoms of Autistic Disorder. Due to the severity of (the individual's) compulsive behaviors and interference in daily activities due to them, a separate diagnosis of Obsessive Compulsive Disorder is re-established. (The individual's) compulsive behaviors and antecedent behaviors to compulsions remain the target of treatment. "*	

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		• Similarly, individual #250 was diagnosed with a developmental syndrome that is associated with a specific behavioral phenotype. The individual was also diagnosed with an anxiety disorder. *"(The individual's) hyperactivity, self injury and sleep disturbance are all symptoms that have been associated with the axis 1 diagnosis of (the developmental syndrome is named). (Individual #250) has also historically engaged in aggression and self injury. As a manifestation of generalized anxiety disorder, (the individual) will perseverate over these events and show a great deal of anxiety coupled with aggression and self injury."* • Individual #306 was diagnosed with bipolar disorder, with oppositional defiant disorder and with narcissistic personality disorder: *"(The individual) carries current psychiatric diagnosis of bipolar disorder type 1 – most recent episode without psychosis, oppositional defiant disorder. Moderate mental retardation and narcissistic personality disorder…..Mood swings: precipitating factors include some other people's comment or actions, or when she wants something or more of something. (The individual) engages in highly dangerous behavior when upset such as screaming, knocking over furniture and hitting others in quick succession. (The individual) displays extremely impaired impulse control and poor frustration tolerance. (The individual is combative violent when upset and has injured others seriously. (The individual) refuses to take responsibility for (the individual's) behavior."* The psychiatrist clarified that in regard to medication treatment: *"Since the patient is currently on medication it is hard to establish (the individual's) baseline. (The individual) is not displaying acute mood symptoms at this time."* To clarify the need for continued behavioral treatment the psychiatrist also stated: *"(The individual's) maladaptive behavior will be addressed through positive behavior support plan."*	

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		• Individual #127 was diagnosed with bipolar disorder, with intermittent explosive disorder, and with mood disorder due to epilepsy. Since the symptoms could be attributed to different processes, several diagnoses were provided, and the uncertainties were carried forward on an interim basis:" *"(The individual) is a neuro developmentally disabled individual who has been residing at this facility for the past (time period). (The individual) has been diagnosed with Bipolar illness, Cerebral Palsy, Temporal Lobe Epilepsy and Moderate Mental Retardation. (The individual's) IQ has been assessed at 40 and adaptive behavior level II. (The individual) appears to have a 4 year history of episodic mood swings, anger/irritability, impulsivity and aggression/belligerence during which (the individual) has attacked family members and staff. These episodes seem to coincide with seizure like activities during which (the individual) is in a trance like state, stares, dissociates and has transient memory loss. (The individual) has walked miles away from home in the middle of the night without any recall. (The individual) talks about hearing god's voice and feeling scared of demons but denies any visual disturbances or having any special powers. (The individual) does report feeling sad at times, especially after (the individual's) disruptive behavior but does not endorse any overt depressive symptoms or any cycling between hyper state and depression. (The individual) has a history of insomnia in the past albeit has been sleeping fairly well recently and has a healthy appetite. Since (the individual's) admission here, (the individual) has had one episode of aggressive behavior and belligerence during which he lunged at a peer abruptly and impulsively before staff intervened. (The individual) is targeted for maladaptive behaviors like PAD and POB, the rates of which are being monitored. (The individual) .ambulates well, engages with staff, verbalizes coherently, enjoys reading his bible or listening to his cds and is fairly independent with his activities of daily living. (The individual) attends school (special education) and reports liking math and phonics. (The individual) has been compliant with ... medication regiment and ... behavior support plan, and appears fairly stable currently without any overt mood symptoms or psychosis. (The individual) denies any suicidal or homicidal ideations at present and seems cognitively intact without any confusion or disorientation."* In the ensuing discussion the psychiatrist also introduced the maladaptive behaviors that were the focus of treatment by colleagues from psychology. Some of the psychiatric assessments that were reviewed were less satisfactory than those above: For example:	

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		• Individual # 258 was diagnosed with Asperger's Syndrome and a sleep disorder. The evaluation from 2009 stated that the psychiatric concern was that "(The individual) had aggressive tendencies toward others, physically disruptive behavior insomnia and preoccupation with food." Information was provided that (The individual) had been hospitalized on multiple occasions at (hospitals named) prior to placement at DSSLC but if records from those hospitalization were obtained, no details were provided. Previous psychiatric medications (including with major tranquillizers) were named, but no details were provided. The formulation was Asperger's syndrome (without further elaboration), a sleep disorder, and (named) medical difficulties. Treatment recommendations resulting from the evaluation were to decrease one medicine, increase a second medicine, and continue all other medications. That evaluation was too brief and did not present a formulation for the primary symptom of aggression. Individuals with Asperger's Syndrome can of course have aggression, but it is not part the syndrome itself and it should have been discussed and accounted for in some fashion, even if the working hypothesis was tentative. • Individual #799 was diagnosed with intermittent explosive disorder. The psychiatric assessment dated from 2008, and the history of present illness consisted largely of descriptions of (the individual's) explosive behavior: *"(The individual) was admitted to State School on 5/11/72 from (facility named) to be closer to his family …(The individual) has a history of explosive behavior for a long time. It has been treated with medication since 1987. It used to consist of verbally disruptive behavior but in the last on year has progressed on to physical aggression toward others, physically disruptive behavior; e.g.: throwing objects, slamming door & stomping. (The individual's) scavenging behavior, consisting of finding cigarette butts & chewing tobacco is mild to moderate in intensity."* Other symptoms are mentioned but were not elaborated upon: *"(The individual) has engaged in talking about his imaginary friends (named) since his childhood. According to staff reports, (the individual) acknowledges that they are not real. The intensity of this target behavior has improved and (the individual) can be redirected fairly quickly. (The individual) is noticed to have an increase in anxiety under demand, stress or in anticipation of a planned activity. (The individual) used to engage in fairly significant self-injurious behavior but it's no longer an issue…."*	

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		The assessment was that: *"It is my opinion and the team consensus to address his explosive episodes with medication adjustment. He continues to have episodes of VDB and recently engaged in property destruction. No significant responses to (names of two medications). "* In this case as well, there should have been a more complete presentation of the chief complaint and history of present illness was needed, since the symptoms of irritability and related aggression are part of a large number of possible DSM diagnoses. In addition, the symptoms of (apparent) self-talk and anxiety warranted more consideration in the diagnostic process. Also, the assessment should have discussed more than the immediate management issues at hand. • Individual # 399 was diagnosed with schizoaffective disorder and fetishism. Per the diagnostic assessment of 05/24/10 *"He has been diagnosed with psychosis not otherwise specified and reports indicate he has displayed psychotic symptomatology since adolescence. One report stated he had bizarre speech with strange thought content, which is fairly consistent with his current presentation. He has, and continues to have, to engage in a myriad of self stimulatory behaviors. These behaviors include humming, waving hands in his face, whispering and blowing into the palm of his hand as he cups his face and ear, and repeatedly singing the phrase "baboo." One report also stated that throughout his time at (name of hospital) he had a string he played with and that he called "Billie." He was apparently quite attached to this piece of string, would reference the string in conversation."* The psychiatrist noted that there were reports of a chronic level of hyper-sexuality, including: *"(The individual made) sexual comments to (gender specified) staff members, talking about going to bed with another (same gender) resident, engaging in public masturbation and exposure and incessantly asking for hugs….Although it is unclear as to the individual's intention regarding children, it is inferred through records, staff report and direct observation that there is some form of sexual interest in children. (The individual will talk about shoe and feet, especially those*	

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		of (gender specified)." The case formulation referring to these issues stated only that (the individual) had a long standing psychiatric and developmental disorder disorders, and diagnoses of schizoaffective disorder and fetishism were given. While these diagnoses are plausible, little was offered in the way of differential diagnosis or exploration of learned behavior as possible explanations for at least some of the symptoms. At minimum the psychiatrist should have discussed why the diagnosis of schizoaffective disorder was chosen over many alternative and equally plausible explanations. Overall, the review of clinical records showed that many, but not all, of the records, fulfilled all the requirements of provision 6 for evaluation. Recent evaluations that followed the Appendix B format were typically better. But some assessments, for example for individual #399, were done in 2010 and did not follow that format. The Facility self assessment clarified that the DSSLC Behavior Services Workgroup is working on improving data. To achieve a finding of substantial compliance, DSSLC psychiatrists should review the existing evaluations of individuals under their care to make sure that diagnoses in place are substantiated by the observable behavioral symptoms that can be the basis for meaningful medication plans, provide some support for the selected diagnoses. If necessary, a clinical update should be provided (see the last paragraph of provision J2 regarding a proposed format).	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric	Per the POI, DSSLC reported that Reiss Screens were completed for all individuals who live at DSSLC. Reiss screens were located in the clinical records of the individuals reviewed by the monitor assigned to psychiatry. Such reviews were done, however, only for individuals who received active psychiatric care. Verification that Reiss screens were completed for individuals who do not receive psychiatric care will be done at next tour of the monitoring team.	SC

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	diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.		
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	SA provision J8 specified that there should be a system to integrate pharmacological treatments with behavioral and other interventions, through combined assessment and case formulation. At DSSLC, psychology and psychiatry shared clinical care responsibilities for all individuals who received psychiatric care. The key working location for joint deliberation about care was the PMR. Psychology and psychiatry worked together closely in the PMR setting and related PST settings. Before each PMR, the psychologist prepared a detailed report along with graphic presentations or data that were a basis for discussion during the meeting. The PBSP was the key document where documentation for the need for behavioral and/or pharmacological treatment was detailed. The BSRC was prepared by the psychologist, who also reported on the status of psychiatric care. The BSRC met weekly to review new PBSPs and updates to existing plans. Over the past six months, psychiatrists started to attend PSP meetings and Dr. Harden joined the meetings of the BSRC. These steps added to interdisciplinary collaboration between psychiatry and psychology, and enhanced the ability of DSSLC clinicians to provide combined and integrated case formulations. The monitor reviewed the PMR and PBSP documentation for each of the 32 individuals listed under provision J2. Each of the clinical records contained a discussion in the PBSP that identified the modalities of treatment that were used. The explanations for the modalities of treatment that are needed were typically included in the HRC review of the PBSP. To illustrate typical PBSP descriptions of required elements of behavioral health care, two PBSP's were selected at random from the 32 clinical records that were reviewed for this compliance tour and relevant section were located as follows: For individual #605, the HRC review of the PBSC from 07/15/10 stated: *"Psychoactive medications are the (the individual's) primary form of treatment for symptoms related to (the individual's) psychiatric diagnosis"* several paragraphs of detailed discussion of the psychotropic medication treatment the individual received The document then went on to describe the many behavioral interventions that parallel the medication treatment. These were summarized in the "justification" section of the HRC review: *""When(the individual) reaches the end of (the individual's limited in relation to social interactions…the individual) often will yell at the staff or resident attempting to interact with (the individual)*	N

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		and if this doesn't make that person go away then (the individual) often becomes aggressive. By reinforcing the less severe forms of behavior it is hoped that verbally disruptive behavior and physical aggression to other will no longer be necessary." For individual #127, in the section "Need for Positive Behavior Support" of the PBSP (implementation date 07/02/10), the following statements were made: *"The PST agrees that formal behavioral support and the use of psychotropic medications remain warranted, given the potential for injury to others. A PBSP will enable staff to carry out the appropriate procedures in order to prevent and manage occurrences of physical aggression to others, while the use of the current medication (two medications are named) will help in management of (the individual's) symptoms related to his current psychiatric diagnosis. A heightened level of supervision was also agreed to ease the transition into (the individual's) new home life."* Many PBSPs contained language that referred to integrated care. The monitoring team examined the process by which PSTs at DSSLC determined that integrated care was needed, and the steps taken by the PST to assure that integrated behavioral care was provided. This was done by observations of PST discussions at PMRs and PSP meetings, by discussions with psychiatrists during the tour, and by reviews of clinical records In particular, the monitoring team tried to determine whether or not psychiatrists and psychologists had a shared clinical case formulation, for individuals who received both psychiatric and psychological care. The monitoring team focused on this point, since a well understood and truly integrated case formulation at the PST level is the key for all subsequent steps of behavioral treatment. Although the Facility had made a good beginning of integrating pharmacological treatment with behavioral and other interventions, it has not yet reach the point of substantial compliance. Several observations suggested that more can be done to assure combined case formulation: • No examples were found by the monitor of PMR documentation which suggested active discussion about alternative interdisciplinary case formulations. For example, a note by a psychiatrist that medication treatments were deferred while psychologists pursued a preference for behavioral interventions would have implied such discussions. • The only apparent formal structure for joint case formulation discussions was the PMR. But PMR time allocations did not differentiate between new and ongoing cases to anticipate a greater focus on new case formulations. In addition, there was no apparent mechanism for senior clinicians (or others at	

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		DSSLC who had particular skills related to the case in questions) to join the PMR on an ad-hoc basis, for discussion about case formulation. Many facilities use clinical case conferences as a format for interdisciplinary case formulation for new/complex cases. Such a format would allow for input from experts throughout the DSSLC community – and if needed invited experts from outside DSSLC – to come together to consider alternative clinical formulations and to contribute to combined case formulation. The monitoring team is unaware of such cases conferences at DSSLC. • During the annual PSP meeting of individual #187, there appeared to the monitor to be significant difference of opinions between the psychologist and psychiatrist regarding the formulation of key aspects of care. Each presented a well reasoned and clinically justifiable understanding of what was needed. The two formulations differed, however, and conflicting recommendations were made. In the opinion of the monitor, the conflicting formulations should have been discussed and resolved, for example at a PMR meeting, much earlier in the treatment process. • Some chart documentation suggested that a joint understanding of cases was not in place. For example in the case of individual #289, the psychiatrist stated in the psychiatric assessment that the individual *"may be attempting to escape from disliked environments. Attention may be a secondary function."* In the PBSC of 01/22/09, however, the psychologist stated that "*the individual's anxious behavior seems functionally related to his psychiatric disorders… (The symptom) does not appear to help…avoid activities or gain attention.* " • Efforts to trace formulations presented to the BSRC back to their source at the PST level in selected cases were not successful. For example, the monitor was not able to do so in the case of individual #127, although this individual was admitted to DSSLC only recently. Documents reviewed in the attempt to do so were the PSP addendum of 04/06/10, the PSP addendum dated 06/09/10: PSP quarterly Review, dated 06/16/10; PSP Quarterly Review dated 03/03/10. • Provision J8 mentioned the need for integration of pharmacological treatments, with behavioral and "other interventions." The monitor assigned to psychiatry did not find consideration of other interventions in the cases reviewed. Such interventions could include treatment of medical conditions that have behavioral manifestations (for example, the complex partial seizure disorder that was part of the clinical formulation for individual #127), or the use of "brushing" or other sensory modulation techniques used by colleagues from	

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		occupation therapy for individuals with autism spectrum disorders. In summary, DSSLC has made many improvements to the interdisciplinary process. The monitoring team identified, however, that improvements are needed in the area of the combined assessment and formulation	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	Provision J9 required that the PST should determine the least intrusive and most positive interventions used to treat an individual's behavioral or psychiatric condition, and to determine whether the individual is best served with medication, behavioral supports, or other interventions. The language of the provision clarified that medication cannot be used without additional treatment/support. Language addressing these considerations was found in the PBSP for each of the 32 individuals who were reviewed. The HRC review of the PBSP focused on required determinations was found in the following PBSP sections: • Program Summary • Justification • Less intrusive approaches previously attempted • Risk vs. Risk Analysis (the focus of provision J10) • Plan to remove restrictive/intrusive component. For purposes of illustration, the language from two individuals who received new medications was reviewed. For individual # 250 the PBSP (update of 9/3/09)was provided to the monitoring team as related to the new medication. **Identification of the Problem and Discussion:** *"(The individual) suffers from anxiety which is usually managed very well. (The individual's) anxiety increases when anticipating visits, holidays or excursions and is more likely to engage in self-injury when (the individual) becomes overly anxious. (The individual) engages in self-injury when favorite trainers or family members are leaving for the day, indicating (the individual's) apparent wish to convince them to remain near (to the individual). (The individual) also attempts to injure (self) when thwarted in wishes, such as when staff members ask (the individual) to stop watching a movie during training times. (The individual) apparently has learned that self-injury will sometimes gain others' compliance with (the individual's) wishes, possibly tangible wishes, or desired outcomes. Additionally, (the individual) can communicate verbally but with some difficulty and staff may also experience difficulty understanding what he wants. (The individual) becomes more anxious and agitated when (the individual) cannot communicate… needs/wants."*	N

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		"(The individual) engages in self-injurious behavior and repetitive behaviors. Most frequently, this is displayed as poking his nose and causing it to bleed, slapping or scratching himself, or striking … head against objects. (The individual) occasionally causes injuries, typically by scratching ...self. Repetitive behaviors are most commonly asking the same question over and over, repeatedly requesting that something be written down, or making an "eeeee" noise. These behaviors are symptoms of (The individual's) psychiatric diagnosis. In addition, (the individual) has problems sleeping, so (the) sleep patterns are tracked and measures are taken to attempt to increase the number of hours (the individual) sleeps each night." **Less Restrictive Practices:** *"Due to (the individual's) Axis I Diagnosis, the PST agreed that the use of … current psychoactive medications (Prozac and Melatonin) continues to be necessary in order to ensure the safety of (the individual's) and others, decrease the probability that severe episodes of problem behavior occur, and to help increase the quality of life for (the individual) by controlling the symptoms of his Axis I disorder(s)."* *"Due to the severity of problem behaviors and the risks associated with episodes of self-injurious behavior (potential injury … social stigmatization), the team agreed that the use of restraints to be the least restrictive method to manage episodes of severe self-injury in the past. The use of restraint was only to be used when other, less restrictive (e.g. prompting, redirection, problem solving), procedures had been attempted first and were unsuccessful."* For individual # 289 the PBSP dated 01/22/09 was provided to the monitoring team as it related to a new medication **Identification of the Problem and Discussion:** *"(The individual) is ambulatory but often requires assistance to walk and uses a wheelchair for long-distance travel. (The individual) often sings hymns or popular songs such as "Autumn Leaves," and "You Are My Sunshine" though these are often difficult to understand. (The individual) has a history of tearing pieces of cloth and mouthing these; (the individual) has done so since childhood, according to his siblings. Approximately 14 years ago, (the individual) began experiencing extreme agitation and mood swings. For instance, (the individual) would abruptly run towards others, rip down curtains, and grab people. Several medications were introduced and changed in an attempt to address these symptoms. Both aggression and crying have been discontinued as formal objectives. (The individual) has had medical problems, such as gastrointestinal distress. Currently (the individual) appears medically and behaviorally stable. On occasion (the individual)*	

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		appears anxious and tense, probably a manifestation of his Axis I disorders (Mental Disorder NOS, Depressive Disorder NOS, and Anxiety Disorder NOS). At such times, (the individual) will grimace and frown, fidget, and appear unable to sit still. Much less frequently, and more by history, (the individual) has crying episodes in which he does not respond to efforts to comfort (the individual). When (the individual) finds small objects or cloth items in his vicinity, (the individual) may put them in (the individual's) mouth. Although in the past (the individual) sometimes swallowed these items, (the individual) has not done so in several years. (The individual) has also created objects to mouth by tearing strips of clothing. However, due to the potential seriousness of Pica, it has been kept as a target." **Need for Behavior Support:** *"The PST recommended continuing a formal BSP targeting Anxious Behavior, Pica/Attempts. A Behavior Support Plan remains warranted to prevent injury to himself due to Pica and to address symptoms of (the individual's psychiatric disorders."* **Attempts at Less Restrictive Practices**: *"Regular interactions and programming were provided for many years in lieu of formal behavioral programming. However, beginning around (date provided), (The individual) began experiencing emotional distress, aggression, and disruptive behaviors. Less restrictive measures were unsuccessful in alleviating these problems, and the consulting psychiatrist recommended starting psychoactive medications. (The individual) has psychiatric diagnoses that are appropriately treated with psychoactive medications. Depakote was reduced on (date provided), resulting in a rapid deterioration in functioning (loss of ability to perform daily activities, extreme agitation, and withdrawal). In addition to treatment with Depakote, Klonopin was recommended by the psychiatrist on (date provided) due to an increase in targeted behaviors. On (date provided), Depakote was decreased from 2750 mg to 2500 mg per day and rates of targeted behaviors have remained stable for a period of time. Depakote was then decreased 2000mg to 1500mg on (date provided) but his target behaviors increased so rapidly that on (date provided) was increased back to 1750 mg a day, where it remained for some time. Over the course of the past year, however, it maladaptive behaviors have been on the incline with limited environmental changes. On (date provided), the decision was to increase the Depakote back to 2000mg. On (date provided), Trazadone was then doubled to 100mg a day. The PST will continue to work with medical staff to find the lowest effective dose for treating (the individual's) psychiatric symptoms. However, at this time, it appears that each decrease in medication immediately results in resurface of negative behaviors".* The clinical records cited above were representative of the clinical records that were	

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		reviewed. These reviews showed that PBSPs contained the required language regarding the requirements of provision J9. At the same time, the requirement for the IDT to determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and to determine the appropriate modalities for treatment, can substantively be best met only through the combined assessment and case formulation process discussed under provision J8. As discussed above under provision J8, the process of such combined assessment needed improvement.	
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.	Provision J10 required that before a medication is administered, the PST (including the psychiatrist, primary care physician and nurse) should determine whether the harmful effects of the illness outweighed possible harmful effects of the medication. Presentations of possible medication side effects were included in the PBSP for each of the individuals. There were also statements that the risks of the illness were greater than the risks of the side effect. The level of detail for description of potential side effect varied considerably from case to case. Often, the PBSP contained a broad description of the side effects of the class of medications taken by the individual, followed by referral to a monograph on the medication that was provided by the pharmacy. This was the case for the two individuals cited in the discussion of provision J8, above. For individual # 250, the presentation for risk vs. risk was as follows: *"The PST has carefully considered and weighed the potentially harmful effects of a drug for psychiatric symptomatology in the antidepressant class (currently Prozac) and sedatives and hypnotics class (currently Melatonin) {please see attached drug monographs for medication side effects and information} against the harmful effects of self-injurious behavior and manifestations of psychiatric symptoms, such as serious injury to (the individual), loss of training opportunities, compromised health due to lack of sleep). The team has determined that the harmful effects of the problem behaviors and symptoms outweigh the potentially harmful effects of Prozac and Melatonin."* For individual # 289 the presentation of risk vs. risk was as follows: *"The PST has carefully considered the potentially harmful effects of drugs in the mood stabilization class, currently Depakote, Trazadone an antidepressant, and drugs in the anxiolytic class, currently Klonopin. For a record of possible side effects, see the Pharmacy Part 1 report. These risks were weighed against the harmful effects of (the individual's) psychiatric disorders, which include emotional distress characterized by agitation, anxiety, and dysphoria. The PST has determined that the potentially harmful side effects of the medications are outweighed by the harmful effects of (the individual's) untreated psychiatric*	N

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		disorders." The level of detail presented in other plans varied considerably. In some PBSPs the information about medication risk were extremely detailed. For example, in the case of individual #605 the PBSP provided the following information: *"Possible side effects of Zyprexa include blurred vision, fast or uneven heartbeat, fever, sweating, confusion or muscle stiffness, increased restlessness or excessive movements, jerky movements of the face tongue or jaw that are not controlled, lightheadedness or fainting, numbness or weakness in the arms or legs or one side of the body, severe sleepiness, slurred speech, or trouble breathing, shakiness & problems with balance, swelling of the hands ankles or feet, swollen breast or liquid discharge from the nipples, or trouble swallowing".* *"Possible side effects of Klonopin include feeling sad, irritable or nervous, fever chills, cough, sore throat body aches, lightheadedness or fainting, severe confusion, drowsiness or muscle weakness, slurred speech, tremors, unusual behavior or thoughts of hurting yourself, unusual movements of the eye, worsening seizures."* *"Possible side effects of Lamictal include blistering, peeling, or red skin rash, bloody stools, blurred or double vision changes in your menstrual cycle, chest pain, extreme weakness, dizziness or fainting, feeling unusually sleepy, sad, grouchy, moody or nervous, fever or chills, pain, soreness or itching in your vagina, painful sores in your mouth or around your eyes, painful urination or a change in how much you urinate, problems with balance or walking, severe muscle pain, swelling in your face hands, ankles, or feet, swollen or tender lymph glands in your neck, armpit, or groin, thoughts of killing yourself, tremors, unusual bleeding, bruising, or weakness, wheezing or troubled breathing, yellowing of your skin whites of your eyes."* *"Possible side effects of Lunesta include abnormal thinking and behavior, anxiety aggressiveness confusion depression or dizziness, burning while urinating, change in how much or how often you urinate, fever chills cough or sore throat, lightheadedness or fainting, numbness or tingling or burning pain in your hands arms legs or feet, rapid weight gain, severe diarrhea."* *"Possible side effects of Haldol include change in how much or how often you urinate, chills cough sore throat and body aches, fast slow or uneven heartbeat, felling very thirsty or hungry, fever or muscle stiffness, jerky muscle movement in*	

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		the face tongue or jaw, lightheadedness or fainting, problems with vision speech or balance, seizures or tremors, trouble breathing or swallowing, unusual bleeding, yellowing of the skin or eyes." *"Benefits: The benefits of participating in this program are that (the individual's) Axis I symptoms will be controlled and she will be more likely to maintain her current level of cognitive functioning and independence for as long as possible."* *"Risks of Not Providing Treatment: The PST unanimously agreed that the risks of medications outweigh the risk of not providing treatment such as a decline in cognitive functioning and increased probability of aggression and harm to self and to others."* During the tour, the monitor asked psychiatrists, psychiatry assistants, and psychologists how they decided which possible side effects of proposed medications were selected for presentation to the individual's guardian and to the HRC. The monitor was informed that during the PMR deliberations about a new medication, the psychiatrist completed a "New Medication Form." That form included a place to list pertinent side effects. The psychiatry assistant then called the guardian for consent, and provided the information about the possible side effects that were identified by the physician. Information about possible side effects was also included in PBSP documentation that was reviewed by BSRC and HRC. That information was collected by the psychologist, who referred to medication information sheets from the pharmacy. The monitoring team requested HRC documentation about new medications, and was provided with the relevant "New Medication Forms. In the case of individual #289 Zyprexa was a new medication that was started in 2010. On the New Medication Form the psychiatrist identified four side effects that were pertinent to the individual receiving the medication. In the case of individual #250 Lexapro was a new medication that was started in 2010. In the case of that individual, specific side effects were not listed in the New Medication Form. Provision J10 required that risk information on new medications should be reviewed by the PST, including the PCP and nurse. The new medication information for individuals #250 and # 289 was examined. In the case of individual #289, the medication was proposed at the PMR of 08/04. Neither the PCP nor the nurse attended that PMR, and per routine the PCP never does. The New Medication Form from that date documents that the PCP approved the medication telephonically. In the case of individual #250, the discussion took place during the PMR of 08/26/10. Neither the PCP nor the nurse appeared to have attended the meeting, per the signature page. Again, telephonic approval was obtained for the physician, but not the nurse.	

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		At the time of the next tour, the monitoring team will review further the process by which side effects are selected for presentation to the guardian and for inclusion in the PBSP. Information from records reviewed suggested that the side effects mentioned on the New Medication Form were selected, since they were the most pertinent possible side effects for the individual in question. If so, an obvious option is for those side effects to be cited/discussed in the PBSP, complemented by a reference to the broader monograph available via the pharmacy and perhaps mailed to the guardian. Identification of the risks associated with medication treatment is a necessary element for informed consent. Informed consent is the focus of provision J14.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	The monitoring team reviewed the practices at DSSLC for tracking of psychiatric polypharmacy. Polypharmacy was identified by pharmacist in the QDRR, and it was discussed at HST meetings. The presence of polypharmacy was one of the criteria used to assess risk. Individuals were considered to be at high risk if they received two or more medications from the same class, three or more medications for the same diagnosis, or two or more medications with the same mode of action. Individuals were considered to be at medium risk if they received a total of nine or more medications. Monthly polypharmacy meetings were also held, and psychiatrists participated in those meetings. Polypharmacy was a focus of the P&TC. In individual clinical records, the pharmacist noted the presence of polypharmacy on the QDRR sheets, and these notes were located in all clinical records reviewed. The main focus for overall review regarding the rationale and planning for management was the monthly polypharmacy meeting. This meeting was attended by the Pharmacy Director, the Medical Director, psychiatrists and primary care physicians. Each month, a Polypharmacy Report was generated following that meeting. The report listed each individual receiving polypharmacy, as defined by SA provision J11. It then named the medications the individual was taking and pertinent facts regarding changes in the medication regimen. Finally, the report provided detailed comments from the treating psychiatrists regarding the clinical need for the polypharmacy and the plans for the coming period. For example, from the most recent available Polypharmacy Report (July 2010): Individual # 494 *Diagnosis of "Schizophrenia, No change in dose Paranoid Type" and (the individual) was reported to be stable while he's on Clozaril and Abilify. Due to the high level of Clozaril we decreased (the individual's) Clozaril by 200 mg on 4/02/10. We checked his blood Clozaril level. It dropped below therapeutic level, and then we increased (the individual's) Clozaril dosage by 100 daily and checked*	SC

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		blood Clozaril level. It turned out to be over upper limit of therapeutic range. The patient was not drooling and not over sedated with no other significant side effects from Clozaril, so we left the patient on the same dosage of Clozaril and have rechecked (the individual's) blood Clozaril level again. The Clozaril level turned out to be 335, so we continued (the individual's) Clozaril on 700 mg per day. Currently the patient is still psychotic with evident delusions and disorganized thoughts. Considering (the individual's) past multiple psychiatric hospitalizations and currently (sic) psychosis we'll continue with Clozaril and Abilify. Individual # 695 (*The individual) is treated with Lamotrigine, Olanzapine and Klonopin for Bipolar Disorder. Haldol was added due to severe agitation and psychosis while (medical treatments listed).Several health problems limit the choice of psychotropic medications. Lithium discontinued recently due to impaired renal function. Haldol was reduced recently and (the individual) remains stable. Will continue to decrease it slowly. (The individual) is no longer on (somatic medication named).* *Reviews of polypharmacy were not limited to antipsychotic medications. Some were for individuals taking two antidepressants from the same class. For example:* *Individual # 28* *Patient will continue both medications for synergistic effect. The two antidepressants have different mechanism of actions. (The individual) responded only partially to two antidepressants (Sertraline and Venlafaxine) at max doses. Mirtazapine is to additionally help(ful) with insomnia.* *Each individual reviewed by the polypharmacy group was reviewed monthly, and updates were provided by the clinicians.* Facility level reviews of medication practices that relate to polypharmacy were also conducted by the Pharmacy and Therapeutics Committee (P&TC). Two such reviews were conducted during the review period. Benztropine use at DSSLC was reviewed in April, 2010, and clonazepam use at DSSLC was reviewed in July, 2010. These reviews were also detailed and substantive. Per the POI, DSSLC there is a plan to review all individuals for polypharmacy but not everyone has been reviewed. At the time of the review, the Polypharmacy Report listed	

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		the individuals who received polypharmacy, and indicated which of these individuals were reviewed by the polypharmacy group. In the most recent review 7/19 individuals were listed as "information not yet available." During the tour the Pharmacy Director indicated that individuals were gradually added. In the POI the Facility indicated that there is a plan to review all individuals. Not everyone had been reviewed. The monitoring team found that review of polypharmacy was detailed and substantive, at both the individual level via the QDRR and discussion that followed in the PMR, and in the monthly reviews described above. The monitoring team noted the plan to add the remaining individuals who received polypharmacy who had not been reviewed at the time of the tour.	
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 system in place at DSSLC was that the nurse case manager completed the required MOSES and DISCUS screens. The results were reviewed in the quarterly PMR, and a place for the results to be documented was included in the template in place for documentation during that meeting. The actual MOSES and DISCUS forms with physicians' review were maintained in the clinical record, and MOSES and DISCUS forms were located by the monitor in all clinical records that were reviewed. DSSLC had an internal monitoring system for MOSES and DISCUS reviews. Documentation from March 2010 review was provided. If the monitor understood the report correctly, the sample size appeared to be very small, consisting of four individuals. Per that audit, the DISCUS was done every three months as required in one of four reviewed records (25%); The DISCUS forms were complete (to include examiner's physician's and psychiatrist's signatures) in two of four (50%) of cases reviewed. The MOSES was done every three months in three of four cases reviewed (75%, with the added note that guidelines had changed in August to every six months). The MOSES forms were complete (to include the examiner's, physician's and psychiatrist's signature) in three of four (75%) of the cases. Prior to the tour, the monitoring team requested a list of individuals with tardive dyskinesia. Such a list was not provided. During the tour the monitor asked about such a list, and was told that there is not yet a facility wide process for monitoring dyskinesia screening results that could provide such as list. Reasons that such as list was needed include: • Individuals with elevated DISCUS ratings should be monitored to assure that appropriate diagnoses were included in the record, and that appropriate clinical steps were considered. At the discretion of the treating psychiatrist, some	N

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		individuals might benefit from general neurology or movement disorder subspecialty consultation. • The level of scrutiny for individuals known to have tardive dyskinesia who nonetheless continue to receive antipsychotics needs to be high. There are of course some clinical circumstances where such administration is warranted. But it is precisely in those cases that a particularly careful risk/benefit analysis must be conducted and the choice of the antipsychotic to be used should be carefully considered. For QA purposes, there should be a review of whether campus wide rates of diagnosed dyskinesia correspond broadly to clinical expectations. For example, most experts estimate dyskinesia rates for older antipsychotics of about 1% per year of exposure. In individuals with neurological brain illness, rates would be expected to be higher. As a practical clinical matter, the number of individuals with scores of "5" or higher on the DISCUS (the cutoff for dyskinesia) seemed to be low. In the case of a least one individual observed by the monitoring team (individual # 287), what appeared to be classic dyskinesia seems to have been missed on the screening. The monitoring team discussed this case with the psychiatrist and other PST members, and it was possible that the movement disorder witnessed was recent and emerged after the withdrawal of Geodon – an emergent dyskinesia. If indeed the overall rate of diagnosis is low for the number of individuals being treated, this could suggest a need for DISCUS training for raters. Facility wide information about the number of individuals who lived at DSSLC who were found to have elevated DISCUS ratings, and who those individuals were should be collected. The information is needed, for both treating clinicians and for committees such as the polypharmacy group and P&TC.	
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	Provision J13 provided detailed expectations for medication treatment monitoring. Following the baseline tour the monitoring team recommended that DSSLC should review practices for generating psychotropic medication plans, and should consider increased use of accepted observer rating tools. In response: • The DASH was selected (but was not yet in place) as a tool for tracking behavioral symptoms. As mentioned under provision J3, the DASH tool is an appropriate tool. It has subscales for various symptoms/symptom clusters. It is particularly well suited for individuals who do not have expressive language. Like any tool, it has limitations, and should not be the exclusive measure used in all cases.	N

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	hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	• The formatting for the PMR was revised. In newer PMRs, psychiatric and behavioral data were recorded separately. • The formatting for the quarterly PMR was revised to include a number of items needed for medication treatment plans. These included a place to list psychiatric symptoms/behavioral characteristics for new medications proposed, the expected timeline for therapeutic effect, and details for monitoring the medication (rating tool, frequency and by whom the ratings would be done). During the tour clinical records were reviewed to assess medication monitoring practices that were in place. To provide the clearest description of whether clinical diagnoses were supported by symptom/behavioral characteristic, whether those symptoms were linked to specific medication treatments, and whether subsequent monitoring of those symptoms was data-based.the monitoring team reviewed the PMR's for the 14 individuals whose records are reported on in the discussion for provision J6 about diagnoses. This analysis revealed: • Individual #108: The most recent PMR provided by DSSLC was for 06/10/2010: The individual was treated with two psychotropics – clonazepam and Seroquel. The format for the meeting was in the older format, and psychiatric data was provided for anxiety and depression. The note indicated that the individual met (unspecified) criteria for "anxiety/depression." The psychiatrist discussed a possible reduction in the Klonopin, and added that Lamictal (for seizures) would provide added mood stabilization. If Lamictal is to be considered as a dual purpose medication, a psychiatric medication treatment plan for Lamictal should be developed and the medication tracked with other psychotropics via the PMR process. Following the psychiatrist's intent, the addition of a measure for mood lability would be appropriate. • Individual #605: The most recent PMR available was for 09/28/10. The individual was treated with five different psychotropics-- Zyprexa, Klonopin, Lamictal, Lunesta and Haldol. The presentation was in the new format. Section V provided data for psychiatric tracking and included ratings for mania, depression, psychosis, and insomnia. The graph indicated that these were measures for severity. The graph presented in the PMR note did not clarify what was being measured, and it was not clear where in the chart one would to look for clarifications on this. No information was included regarding which medications were tracked with which ratings. Such information need not be repeated for each PMR, but it should be available somewhere. Since the individual's diagnosis was bipolar disorder with psychotic features, it was not	

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		difficult to connect some medications and symptoms. One could reasonably link Zyprexa and Haldol to psychosis, and Lamictal was likely used for antidepressant effect. Lunesta was likely prescribed for insomnia. Klonopin, however, could be used for a number of symptoms. In future medication treatment plans, such information should be explicit. • Individual #289 was diagnosed with bipolar disorder and had symptoms of mood lability, depression, and anxiety. The most recent PMR was from 08/04/2010 and was in the new format for presentation. The graphic psychiatric data was separated from the behavioral data. Psychotropic medications reviewed were Depakote and Trazadone. Since the presentation format was new, no data were presented, but the template indicated that measures would be provided for decreased sleep, agitation, and hitting others. Section II of the review format clarified that that interrupted sleep was an ongoing issue for the individual. Trazadone was likely used for sleep. No data were collected for depression. A note stated that in the past the individual had made comments about other people dying and that (at that time) the individual appeared sad This helped clarify that depression might be a needed measure, although it appeared that it was not needed at the time of the review. It appears that Depakote was used in relationship to agitation and hitting others. If so, it should be clear that this was the case. During the PMR, the psychiatrist decided to start Zyprexa and identified mood lability and restlessness as the target symptoms. Target symptoms, including an expected time line, and the proposed use of DASH II for monitoring targeted behaviors per PBSP were identified. • Individual #562 was diagnosed with Bipolar Disorder with psychotic features. The individual was treated with Depakote, desipramine and Risperdal. The most recent PMR provided to the monitor was from 06/29/10. It was in the older format and did not provide separate graphics for medication. Data were reported for PAO, VDP, and related psychological measures. In the psychiatrist's notes there were comments about (lack of) psychomotor agitation/retardation, anxiety, depression, mood lability, and psychosis. This suggests that some subset of these would be used in the future. • Individual #18: was diagnosed with generalized anxiety and was treated with Risperdal and Depakote. The summary of psychiatric diagnosis/history stated that the individual did not take medications until 10 years ago. At that time the individual was living in a group home and began having "outbursts," threatening others verbally and (exhibiting) some aggression toward staff. The individual was diagnosed with an impulse disorder and treated with Abilify and Dilantin.	

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		At the time of the most recent PMR (11/23/09) the individual was treated with Depakote and Risperdal. Abilify had been tapered and discontinued due to lack of efficacy. Depakote was identified as being prescribed for problem behaviors such as aggression and agitation. The most recent PMR (06/23/2010) stated that the individual was fairly stable at the time of the review. Individual # 18 seemed to be pending for transition to monitoring of psychiatric symptoms. When that is done it would be helpful to discuss whether or not each medication is still needed. If so, the psychiatric target and goals should be clear. Appropriate measures to determine progress should be identified. • Individual #494: was diagnosed with paranoid schizophrenia during the psychiatric evaluation of 03/26/10. The most recent PMR provided was from 08/17/2010. The individual was treated with Clozaril and Abilify, two atypical antipsychotics. The new format graphic format was used but psychiatric tracking measures were not yet in use. The psychiatrist assessed that the individual was still delusional, although his sleep was better and he had fewer side effects. • Individual #172: was diagnosed with ADHD and conduct disorder. The most recent PMR was on 09/28/10. The individual was treated with three psychotropics – Lunesta, guanfacine, and Depakote. Psychiatric tracking was in place for hyperactivity/impulsivity and for insomnia. The graphed data (up to 09/01) documented worsening of insomnia and "hyper/impulse," and the psychiatrist noted that the individual stopped the medication four days earlier and had been doing well since then. Review of this case showed close concordance of observer data with clinical impression during the meeting. • Individual #35 was diagnosed with autism and OCD. The most recent PMR was on 08/04/10. The individual was treated with Prozac and Abilify, and tracking was in place for irritability and repetitive behaviors. Repetitive behavior was a shared symptom between psychiatry and psychology, but the psychiatric assessment explained why this was so. Tracked data clearly demonstrated the advantage of Luvox over Prozac as a treatment for repetitive behaviors. The relative stability of the individual and well-presented data allowed the psychiatrist to consider possibility of discontinuation of Abilify, a medication with a greater number of possible side effects. The discussion was clear. The discussion in case #035 provides information that is lacking in case #018. • Individual #250 had symptoms of hyperactivity, self injury, sleep disturbance, and anxiety. The individual participated in a PMR on 08/26/10. At that time the	

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		individual was treated with Prozac, melatonin and Trazadone. The PMR form indicated that psychiatric tracking would be for insomnia and generalized anxiety disorder, although tracking was not yet in place. The psychiatrist noted that the individual had continued difficulty with signs of anxiety and was involved in an episode of aggression toward another individual. Discussion about medication alternatives followed and the reason for replacement of Prozac with Lexapro was well explained. • Individual #306 was diagnosed with bipolar disorder and treated with Depakote, Seroquel, Haldol and Cogentin. The most recent PMR provided was from 08/04/2010. Separate data were provided for psychiatry. The form identified psychiatric monitoring for depression and aggression, although data were not provided for depression. The psychiatrist noted that the individual appeared happier, was eating better, and was sleeping better at night. This suggested that these could be measures for the individual's mood state. Twitching – perhaps a side effect of the antipsychotic medication - had improved. MOSES ratings done by nursing on 02/16/10 and 08/12/10 were negative. Mood and behavior were noted to be stable and the psychiatrist commented that Seroquel taper could be restarted. The psychiatrist mentioned that physical issues and behavior had improved since Depakote was started but no baseline for rating was provided. • Individual #127 was seen in PMR on 08/04/10. The PMR templates stated that the individual was treated, for schizoaffective disorder, with Depakote and Seroquel. Per the psychiatrist's notes the individual also took Tegretol. The new format for psychiatric tracking was in place but data were not collected yet. Behavioral data were provided for aggression and elopement. The psychiatrist noted that the individual was stable since the increase in Seroquel and Tegretol, and had no evidence of mood lability, anxiety/agitation or paranoia. This suggested that these symptoms might be relevant for psychiatric tracking in some fashion. Other cases were less satisfactory: • In the case of individual #258, medications were used for sleep difficulties. Comparison of PBSP updates and PMRs showed that a number of medication changes were made that were not included on medication graphs presented for discussion at the PMR, that the pharmacist repeatedly commented in the QDRR that there were no identified targets for the medications, and that the	

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		psychiatrist repeatedly asked for some tracking of sleep but this was not done. • Another example was Individual #799, who was diagnosed with intermittent explosive disorder. At the time of this PMR on 08/16/10 the individual was treated with Risperdal, Depakote, Trileptal, Cymbalta and lithium. It was not clear what the purpose of each medication was. There was tracking for "anxiety" but it was not clear what was rated. The psychiatrist documented that the individual had mood instability and experienced daily outbursts at home. Other staff reported that that the individual had paranoid behavior such as thinking people are talking about him, which could perhaps be the basis of the antipsychotic. Generally, the need for treatment was clear, but the overall plan for medication use was not clear and the symptom tracking was minimal. • Another example was that of individual #399, who was diagnosed with schizoaffective disorder. Per the PMR of 07/28/10, the individual was treated with Zoloft , Prozac, Haldol and Inderal. There is a report that he is treated for psychiatric symptoms which are not specified, the baseline for these is listed as "tbd," and the discussion of the psychologists in recommendations was described in terms of target behaviors such as physical aggression to others. Overall, DSSLC started to develop the medication plans that are required by provision J13, and the initial steps were positive. The process put in place, however, appears limited to completion (during the PTR) of the lines for new medications that were added to the quarterly PMR template, and completion of the "New Medication Form." In the assessment of the monitoring team, these steps alone cannot accomplish the medication treatment plan requirements of J13. The reasons for this assessment are: • The process of generating a meaningful medication treatment plan can be more complex than is immediately evident. For example, once the psychiatrist has selected a medication and has identified the desired effects of the medication, the psychologist and psychiatrist must select measures which will be used to evaluate how this will be measured. When the selection of measure is not obvious, the psychologist might want to reflect, to consult with colleagues, or to review the applicable professional literature. The psychologist might want to examine both the symptoms the individual displays, and the items on subscales usually used to track for the relevant symptom clusters. If the two do not match, a different measure should be selected. The monitoring team doubts that the needed process can always be completed in real time, during the PMR. • The required medication plans also call for PCP participation, but the PCP does not	

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		attend the PMR. Under provision J8 the monitor identified that the facility needs to improve PST processes for joint case assessment and formulation. There are currently few vehicles for the PST to use, to provide key language documenting the shared understanding between psychology and psychiatry, regarding treatment needs and goals. The new medication plan developed by the psychologist and psychiatrist is an opportunity for the two disciplines to consolidate a shared understanding of some symptoms and treatments. Identification of key wordings/understandings in the new medication review, in a manner that can be carried forward to enduring documents such as the PBSP, could provide much needed clarity. Moreover, once the psychiatrist has stated clearly for the record what the purpose is for the medicine and how the PST will determine if it is effective, there should be a reduced need to repeat that information elsewhere. One option DSSLC could consider is for new medication plans to be started, but not necessarily completed, at the time of the PMR. The PCP could review/discuss the plan when it is more complete. Such a plan could be the repository of needed information about the medication that will eventually be included in the PBSP (see related discussion under J8, J9, and J10).	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	The monitoring team reviewed DSSLC procedures to obtain informed consent prior to administration of psychotropic medications. New Medication Order Forms were reviewed for individuals recently prescribed psychotropic medications, as was HRC documentation of the review. However, the process for selecting which side effects to present while seeking consent was not standard, and the information provided varied. Identification of the risks associated with medication treatment is a necessary element for informed consent.	N
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the	In the baseline report, the monitoring team recommended that DSSLC review practices for tracking whether anticonvulsant medications are used for psychiatric and/or neurological indications. The monitoring team also commented on the need for improved communication between the psychiatrists and the consulting neurologist	SC

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	neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	regarding the joint care of individuals who received both neurological and psychiatric care. In the SPOI DSSLC responded to these concerns and commented that the psychiatrist(s) and pharmacy were currently keeping track of dual purpose anti-seizure medication indications. In July, 2010, a process was to begin to discuss these cases with the on- site neurologist. During the tour the monitoring team requested and received an up-to-date list of the dual purpose medications. The monitor also confirmed the successful initiation of a schedule under which the DSSLC psychiatrists meet with the neurologist and have the opportunity to discuss shared cases. Both the nurse who coordinates the neurology clinic and the psychiatrists confirmed that the meetings are clinically productive and promote shared and coordinated care.	

Recommendations:

1. Continue deployment of the new format for psychiatric evaluations, per SA J6, and continue to focus on identifying distinct markers for psychiatric illness. The monitoring team would appreciate clarification about what DDSLC plans are for periodic (annual?) psychiatric reevaluations/summaries/updates.
2. Explore ways to improve combined case assessment and case formulation, and improved codification of such formulations into the PBSP, per discussion for provisions J8 and J9.
3. Improve the presentation of risks associated with proposed medication treatment, per discussion for provision J10.
4. Establish facility wide tracking of individuals with elevated rating on the DISCUS, per discussion for provision J12.
5. Continue the development of medication treatment plans, per discussion for provision J13.

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. Documents that were reviewed included the annual PSP, PSP updates, Special Program Objectives (SPOs), Positive Behavior Support Plans (PBSPs), treatment data, teaching data, progress notes, psychology and psychiatry evaluations, physician's notes, psychotropic drug reviews, consents and approvals for restrictive interventions, safety and risk assessments, and behavioral and functional assessments. All documents were reviewed in the context of the POI and Supplemental POI and included the following individuals: #14, #20, #45, #78, #79, #94, #110, #123, #127, #134, #172, #182, #222, #229, #269, #297, #306, #334, #335, #337, #349, #381, #406, #449, #451, #482, #483, #488, #490, #537, #540, #578, #590, #606, #619, and #781. 2. Counseling/psychotherapy plans for individuals #79, #110, #483, #781 **People Interviewed:** 1. Randy Spence, MS – Director of Behavior Services 2. Jim LeVell, Ph.D., BCBA-D 3. Lori Powell – Settlement Agreement Coordinator 4. Frank Padia – Director of Program Coordination 5. Shillonda Perkin – QMRP Educator 6. Rosalyn Montgomery – QMRP (Cedar Falls) 7. Sheila Carpenter – Director of Life Skills Development 8. Linda Ford - Director of Active Treatment 9. Barbara Herndon – Director of Vocational Services 10. Luz Mendoza – Director of Recreation 11. Joy Sibley – Director of Communication Therapy 12. Elaine Davis – CTD Director 13. Danielle Jones – Program Supervisor 14. Karen Slaughter – Building Coordinator (512C) 15. Ruth Starrett – Speech Tech 16. Renee Dotson – Speech Tech **17.** Approximately 20 direct care staff **Meetings Attended/Observations:** 1. Positive Behavior Support Committee 2. Joint Positive Behavior Support Committee/Physical Nutritional Management Committee 3. Observations were conducted in the primary workshop, as well as 502, 503, 512, 522, 523, 524 and 525 4. Training of one DCP by psychologist at 508C 9/30/10
	Facility Self-Assessment:

	The Facility indicated that no full provisions of the SA were in substantial compliance, although a number of actions had been taken and some elements of Provisions K1, K2, K3, K10 and K13 were in substantial compliance. For all but Provision K3, the Facility's self-assessment would appear to be valid. In regard to Provision K3, pertaining to peer review, progress toward compliance consisted primarily of having a peer review process in place. Reviews of PBSPs, however, reflected that the peer review process was not achieving the necessary goal of improving the quality and efficacy of PBSPs. Therefore, substantial compliance was not evident.
	Summary of Monitor's Assessment: **For Provision K.1:** This Provision was determined not to be in compliance. The Facility had made progress in increasing participation in classes for BCBA preparation, as well as offering a behavioral "boot camp." Despite noted progress, the Facility was not able to demonstrate that PBSPs had been developed by personnel competent in applied behavior analysis. **For Provision K.2:** This Provision was determined not to be in compliance. The Director of Behavioral Services possessed all required qualifications except for board certification as a behavior analyst. He was participating in classes and supervision, and anticipated sitting for the board certification exam within the next several months. **For Provision K.3:** This Provision was determined not to be in compliance. The Facility presented both internal and external peer review processes. Evidence at the time of the site visit did not demonstrate that the peer review processes were successful in ensuring that PBSPs comported with acceptable practice in applied behavior analysis. **For Provision K.4:** This Provision was determined not to be in compliance. Numerous limitations in data collection procedures were documented during the site visit. In addition, many reviewed records reflected an inability of the facility to effectively monitor responses to interventions and conduct the necessary modifications to assessment and intervention plans. **For Provision K.5:** This Provision was determined not to be in compliance. Documentation at the Facility reflected that assessments were rarely conducted as frequently as necessary or in a manner that produced meaningful results. No records reviewed included adaptive or intellectual assessments conducted within the stipulated time frames. Functional assessments often lacked all essential components and typically did not produce specific hypotheses regarding function. **For Provision K.6:**

	This Provision was determined not to be in compliance. Based upon the documentation in the record, assessments were not demonstrated to be current, accurate, or complete. **For Provision K.7:** This Provision was determined not to be in compliance. While all individuals recently admitted to the Facility had a Psychological Assessment, there were no indications that new intellectual or adaptive assessments were conducted once a person began to live at the Facility. **For Provision K.8:** This Provision was determined not to be in compliance. At the time of the site visit, the Facility had identified persons in need of counseling or other non-PBSP services, but no plans had been developed. **For Provision K.9:** This Provision was determined not to be in compliance. The necessary consent and approval forms were available for most individuals. Limitations in the behavior assessment process did not provide sufficient information to allow for true informed consent. **For Provision K.10:** This Provision was determined not to be in compliance. The Facility had not implemented a routine procedure for assessing the quality of behavior data. In addition, graphs often presented data in a manner that allowed data trends to be misinterpreted. **For Provision K.11:** This Provision was determined not to be in compliance. Many staff had difficulties in understanding and/or implementing behavior interventions due to the complex language, layout, and organization of the plans. In addition, at the time of the site visit, the Facility did not routinely assess the implementation of PBSPs. **For Provision K.12:** This Provision was determined not to be in compliance. The Facility did not employ a competency-based approach to staff training. In the majority of cases, training on PBSPs was typically conducted only when the PBSP was first implemented. In addition, the Facility had not developed or implemented a system to ensure that pulled or relief staff were provided with training on PBSPs. **For Provision K.13:** This Provision was determined not to be in compliance. The Facility fell far short of the required ratio of one BCBA for every 30 individuals. Even when all staff currently working toward BCBA credentialing has earned board certification, the Facility will not have met the requirements of this provision. In consideration of the fact that acquiring board certification can require up to three years, aggressive efforts will be needed to increase the number of employed BCBAs within the time stipulations provided under the Settlement Agreement.

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Since the baseline visit to DSSLC, the Facility had made progress toward ensuring that all staff were demonstrably competent in applied behavior analysis. Evidence of this progress included the following actions. • The number of BCBAs on staff had increased by one, for a total of five staff with board certification. • Three Behavioral Services staff had enrolled in BCBA preparatory classes at the University of North Texas. In addition to staff with board certification, the Behavioral Services department conducted at the University of North Texas a required behavioral "boot camp" for all Master's and Doctoral staff not formally pursuing board certification. This boot camp consisted of 40 hours of classroom instruction and practical experience in applied behavior analysis. All participants were required to achieve at least 70% correct responses on a post-test. Those not achieving at least 70% were required to participate in supplemental training until a 70% was earned. The steps taken by DSSLC were indicative of progress toward meeting the credentialing and competence requirements of the Settlement Agreement. Nevertheless, approximately 52% of the Behavior Services department had yet to participate in more than the 40 hours of boot camp training. One week of training is not commensurate with board certification in applied behavior analysis. In order to ensure that PBSPs meet the conditions set forth in the Settlement Agreement, considerably more progress will be needed in this area. At the time of the most recent site visit, numerous PBSPs at DSSLC did not meet standards of practice in applied behavior analysis. As discussed in Provisions K4, K5, K6, K7 and K9, many components of effective behavior analysis and intervention were not adequately utilized in the development of these PBSPs.	N
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	At the time of the site visit, DSSLC employed a full-time director of Behavior Services, Joseph Randall Spence. Mr. Spence had extensive experience in the field of intellectual and developmental disabilities. The only area in which Mr. Spence was rated at less than fully successful in complying with the settlement agreement was in the area of credentialing. At the time of the site visit, he was actively continuing course work and supervision in order to earn board certification as a behavior analyst. When he has earned board certification, his role as director of Behavior Services will be in full	N

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	care throughout the Facility.	compliance. During the baseline visit to DSSLC, a schism was noted between those members of the Behavioral Services department with strong experience in applied behavior analysis and those staff members who lacked such experiences. During the most recent visit, this schism had lessened substantially. Despite this observable progress, it was reported by the Facility that some tension continued within the department. Mr. Spence provided meeting minutes and other documentation to support his continuing efforts to meet with staff and resolve any remaining issues.	
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.	DSSLC, at the time of the compliance site visit, continued to implement the internal and external peer review process noted during the initial baseline visit. The internal peer review committee was coordinated by the Behavioral Services staff members that are board certified as behavior analysts. Observations of a committee meeting, as well as a review of committee minutes and discussion with staff, revealed active application of a sound peer review model. External peer review continued with the process noted in the baseline visit that consisted of review of assessment and interventions by a contractual employee with board certification as a behavior analyst. It was evident that at least some external peer review was not completed prior to the implementation of a PBSP. This limitation introduced the potential for inadequate PBSPs to be implemented. In addition, if substantive changes are made to a PBSP based upon external review after the PBSP has been approved by the relevant committees and consent has been obtained, the approvals and consent would be of questionable validity, and new approvals and consents may be necessary. In addition to adhering to acceptable standards for peer review, any peer review process must demonstrate that the goal of ensuring acceptable and clinically sound interventions must be met. As discussed in Provisions K4, K5, K6, K7 and K9, many components of effective behavior analysis and intervention were not adequately utilized in the development of 36 of 36 PBSPs reviewed. As a result, evidence indicated that the purpose of peer review was not being met by the current process. Based upon the data obtained during the most recent site visit, although many elements of a successful peer review process were in place at DSSLC, peer review was not successful in meeting expectations.	N
K4	Commencing within six months of the Effective Date hereof and with	Considerable deficits were noted in the collection of behavior data during the baseline site visit. Based upon statements provided by DSSLC staff and supported by observations	N

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	full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	and record reviews, data collection practices remained essentially unchanged at the time of the most recent compliance site visit. Total frequency data collection remained the most common method for measuring behavior. Staff reported, and observations and progress notes supported, that at times it was difficult to collect data as indicated in the PBSP. In those limited instances when efforts were made to implement more formal training and data collection procedures, staff did not gather data in some cases. For example: • Discrete trial training included in the PBSP for individual #222 was not conducted for several months and no data were collected. The Facility did not have an effective process in place to monitor and review the progress; an effective process would identify that the training had not been conducted, so that corrective action could be taken. The data system also needs to be more sensitive to each individual's needs. That is, in addition to being simpler for DCPs to collect, the data system needs to be able to assess both behaviors that occur at low rates, as well as behaviors that occur at very high rates (e.g., stereotypes, undesirable verbal behavior) with accuracy. Depending on the target behavior and its frequency, the facility should use a range of measures, such as frequency, time sampling, and duration measures. It is recommended that the facility expand its data collection system to allow it to assess the occurrence of all target and replacement behaviors accurately. Many Behavioral Services and other staff acknowledged substantial weaknesses in behavior data. Despite such concerns, there was not any routine assessment of the actual quality of behavior data. Except in isolated cases that were verbally reported, there was no attempt to measure data reliability or interobserver agreement (IOA). The Behavior Services department at DSSLC used spreadsheet software to compile treatment data and generate data graphs and progress notes. Although the data entered into this software were of questionable value, the software itself was sophisticated and useful. Most elements required in a data graph were present and the graphs were not overly complex. One weakness seen across all reviewed graphs was a lack of any indicators for changes relevant to monitoring behavioral progress. For example, if the dosage of a medication was changed or the individual was exposed to an environmental stressor, there was no indication on the graph of when the event occurred. Without such indicators, it was very difficult to identify the relationship between behavior, treatment effects and confounding variables. The same limitation was also noted on PBSP progress notes and the data graphs supplied for the monthly review of psychotropic medications. An additional limitation that was	

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		evident on these printed graphs involved differing alignment when comparing the data graph and the data table typically presented immediately below the graph. In numerous records reviewed (but not all), the two corresponding months do not align. For example, the point on the X-axis of the graph for March, 2009, may be positioned directly above the tabular column for January, 2009. The interval for which there was a data point in the graph did not, in these cases, directly correspond with the interval in the table column immediately below. A graph might include a data point representing 13 displays of pica during April, but the table column immediately below the data point included data for February. Although this was a rather subtle difference, it could lead to a misinterpretation of response to treatment. Compounding this issue was the inclusion of psychotropic drug dosages in the tables without any demarcation of drug dosage changes on the graphs. It was easy to mistakenly perceive that a drug dosage change had taken place in one month when in fact the change had been implemented two or more months earlier (because of the misalignment of table and graph). Inclusion of treatment condition change lines on the graphs would alleviate this problem is reduce the probability of misinterpreting the individual's response to treatment. Furthermore, the frequent use of multiple drugs for multiple behavior targets renders tabular data even more difficult to follow when tracking treatment response. It is difficult at best when reviewing these drug data tables to identify relationships between dosage changes and target changes. As a result of the issues presented above, it was not possible in the majority of cases to determine whether a PBSP or psychotropic medication was providing any benefit to the individual or even if it is causing harm. Substantial changes in data collection practices, as well as environmental resources and conditions, will be necessary for DSSLC to make progress toward meeting this portion of the Settlement Agreement. Regardless of the quality of the data, DSSLC made poor use of the data in monitoring efficacy of the PBSP. In 15 of 36 records reviewed, treatment decisions were not supported by available data or data clearly reflected poor treatment response with no following changes in PBSP. • Individual #134 had new replacement behaviors added to the PBSP in March, 2010. Short term benefit was noted in the undesired behavior, followed by a rebound with the undesired target behavior remaining above baseline for multiple months. No further changes in the PBSP were implemented. • The PBSP for Individual #182 explicitly stated that the reason for a revision to	

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		the plan was the annual staffing despite indications well prior to that time that the PBSP was ineffective. • Individual #490 began experiencing elevation in undesired behaviors in December, 2009. No increases in the replacement behavior were documented. A review of the functional assessment or PBSP was not conducted. Risperdal was increased in March, 2010, with no documented benefit. No further changes in the treatment regimen were made. • Individual #578 began experiencing increases in undesired behavior in December, 2009. A replacement behavior was added to the PBSP in March, 2010. Although increases in the replacement behavior were documented, the undesired behaviors also continued to increase. Despite these indications that the replacement behaviors were not functionally related to the undesired behaviors, no further assessments or revisions to the PBSP were attempted. Only one of 36 records reflected a prompt change in the treatment regimen following a poor therapeutic response. • Changes in psychotropic medication were introduced for Individual #488 in May, 2010. Soon thereafter, the individual exhibited extreme spikes in the frequency of undesired behavior. The psychotropic medication regimen was revised as quickly as prudent following the spike in behavior and the individual responded well. The inclusion of replacement behaviors derived from a robust functional assessment is essential in the development of effective behavior interventions. Not only should a PBSP include methods to increase functionally equivalent replacement behaviors, but efforts to assess the efficacy of a PBSP must include steps to determine that the replacement behavior is functionally equivalent to the undesired behavior. If data reflect that changes in replacement behavior are not correlated with opposite changes in the undesired behavior, then this evidence suggests the possibility that the two are not functionally equivalent. Under such circumstances, a revision of the PBSP must be considered as the strengthening of the replacement behavior is unlikely to result in a reduction in the undesired behavior. In none of the records reviewed at DSSLC was the PBSP revised due to the lack of functional equivalence between the undesired and replacement behaviors. It should be noted in all PBSP progress notes reviewed that data graphs reflected only psychotropic drug treatments despite each of the individuals involved also receiving behavior interventions. This is of concern, as it suggests that the primary mode of treatment for individuals living at DSSLC, regardless of whether the target of concern involves mental illness or learned behavior, is psychotropic medication.	

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		• In 36 of 36 (100%) of records reviewed, progress notes did not differentiate between treatment targets. One of the key features of applied behavior analysis is the use of an empirical or scientific process to ensure that interventions produce observable and measurable changes in the targeted behavior. This requires that the target of the intervention consist of a single behavior or a group of behaviors, called a functional class, that have been proven to serve the same purpose under the same conditions. In order to determine the success of the intervention, measurements and treatment decisions must focus only upon the specific behavior or functional class. Frequently at DSSLC, data and progress notes did not focus upon the specific behavior or functional class, instead presenting a variety of target behaviors with no indication that they would be similarly affected by the same intervention. Because the same interventions might have varying effects on different behaviors that are in different functional classes, grouping the target behaviors into one aggregate data point may mask the effects of the intervention, as one behavior might increase while another decreases. The Facility needs to take great care in establishing goals and in gathering and reviewing data so that the data can be useful in making treatment decisions.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	The Behavioral Services department was asked to provide a "best work" sample from each staff member within the department. This sample of 13 records was used to assess the current status of behavior assessment and intervention at DSSLC. Documentation provided by the Facility indicated that in no area of Provision K5 was there substantial compliance with the Settlement Agreement. A review of records indicated that the Facility assessment was accurate. Intellectual and adaptive testing results play an integral role in understanding an individual. While a functional assessment may provide vital information regarding a single behavior or functional class of behaviors, intellectual and adaptive testing provide insight into current skills of an individual and techniques likely to be effective in facilitating learning and promoting behavior change. Such testing can also facilitate the selection of skills the individual can learn. To be useful, however, it is important that the tests be relatively recent, within one year for adaptive testing and five years for intellectual testing. In addition, interpretation of the results of the tests must go beyond the reporting of scores and elaborate upon specific abilities and limitations, and how those abilities and limitations are manifested in the person's daily activities. In 11 of 13 records (85%) from in the sample, a document indicated to be the Psychological Assessment was included. In none of the 11 Psychological Assessments was there documentation to support that the information contained in the Assessment	N

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		was current, accurate and relevant to the understanding of the individual's strengths and needs. • Zero of 11 (0%) Psychological Assessments contained findings from an intellectual test administered within the previous five years. • Zero of 11 (0%) Psychological Assessments included a narrative summary of how the results from intellectual assessments more than five years prior would facilitate the understanding of the individual's strengths and needs. • One of 11 (9%) Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment. • Zero of 11 (0%) Psychological Assessments included a narrative summary of how the results from adaptive assessments current or otherwise would facilitate the understanding of the individual's strengths and needs. • Individual #488 has been diagnosed with dementia, making routine assessment of intellectual and adaptive abilities especially important. The most recent intellectual or adaptive tests results included in the Psychological Assessment were completed in January of 1988. A comprehensive Psychological Assessment must also include at least an adequate functional assessment, if not a full analogue functional analysis, if the individual presents with a behavior disturbance or indications of a mental illness. As the sample of best work provided by the Behavioral Services department was to involve an individual for whom a PBSP had been developed, it was expected that each record in the sample would include a current and acceptable functional assessment or analysis. This was not the case. • Zero of 13 (0%) of records in the sample included a formal functional assessment process that would meet accepted standards of applied behavior analysis. The assessment of behavioral function is more than the completion of a screening tool, interview or series of observations. Determining the function of a behavior is an empirical process that begins with general observation and progresses with increasing control and focus through screenings, interviews and formal observations until a specific hypothesis regarding the function or purpose of the undesired behavior is developed. An acceptable functional assessment or functional analysis does not produce a series of conditional statements regarding the function of the undesired behavior. Rather, the product of the assessment process is a specific statement regarding the most likely function of the behavior. Conditional statements are indicative of an assessment process	

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		that has not been completed. • Zero of 13 (0%) functional assessments produced a specific statement or hypothesis of function. • Seven of 13 (53%) functional assessments consisted of procedures conducted a year or more prior to the initiation date of the PBSP. • Two of 13 (15%) functional assessments did not describe any formal assessment procedures. • Eight of 13 (62%) functional assessments consisted only of screening instruments. The assessment of mental illness is also an integral part of the Psychological Assessment. In people with intellectual and developmental disabilities, the assessment process must contribute to diagnosis of the mental illness being experienced by the individual, as well as determine which undesired behaviors are primarily related to mental illness, which behaviors arise primarily due to learning and the environment, and which may reflect a combined origin of mental illness and the environment. To accomplish this task, assessment should consist of an objective assessment of mental illness using an instrument or process designed for people with intellectual and developmental disabilities, as well as a functional assessment. All 13 records included in the best work sample provided by the Behavioral Services department involved individuals diagnosed with at least one mental illness and prescribed at least one psychotropic medication. Observations, interviews and record reviews revealed that substantial weaknesses existed in the process of diagnosing mental illness and developing acceptable interventions. Most often, Psychological Assessments did not integrate the objective assessment of mental illness into the evaluation process or include behaviors correlated with mental illness in the functional assessment process. • Five of 13 (39%) Psychological Assessments included a copy of an instrument designed for the assessment of mental illness in people with intellectual and developmental disabilities. • Zero of 13 (0%) Psychological Assessments integrated mental illness into the functional assessment process. • Zero of 13 (0%) Psychological Assessments integrated mental illness assessments into the findings of the assessment report. They did not include comment on how the findings of the psychological assessments provide information on observed symptoms and their relationship to target behaviors, the findings from mental health rating scales, or how medication effects or side	

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		effects might affect functions identified for target behaviors or learning goals (for example, whether drowsiness might increase isolation and reduce opportunities to learn socialization).	
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.	Based upon the information presented in K5, minimal documentation in the record reflected assessment findings that were demonstrated to be current, accurate or complete.	N
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.	Records reflect that individuals newly admitted to the Facility had a psychological assessment completed within 30 days of admission. Records did not reflect that individuals admitted to the facility routinely received an intellectual or adaptive assessment at the time of admission regardless of the duration of time since the most recent assessment. Observations indicated this pattern continued throughout the time an individual lived at the Facility. There were no indications that new intellectual or adaptive assessments were conducted once a person began to live at the Facility. • Zero of 36 records (0%) included an intellectual assessment that had been administered within the past five years or an adaptive assessment that had been completed in the past year.	N
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	At the time of the site visit, no individuals were involved in psychological services other than PBSPs. The Facility reported that four individuals had been identified as in need of counseling services, but that neither such services nor the policies supporting those services had been implemented. Due to the lack of treatment plans, it was not possible to review non-PBSP psychological services at DSSLC. As this provision calls for the provision of such services when the need has been identified, at the time of the site visit the Facility was not in compliance with this provision of the Settlement Agreement.	N
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary	The Facility had a PBSP in place for each individual identified as requiring behavior intervention. Consents and approvals are routinely obtained for PBSPs, restrictive procedures and the use of psychotropic medication. The majority of consents met basic time frames and procedural requirements, but some lapses were noted during the site	N

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	approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	visit. • For Individual #182, the PBSP received consent from the LAR on 7/6/2010. The same PBSP was reviewed and approved by the Human Rights Committee on 8/9/2010. The Positive Behavior Support Committee reviewed the PBSP on 8/4/2010, stipulated that revisions were necessary prior to implementation and approved the revised plan on 8/12/2010. Although revisions were made to the PBSP following consent and HRC approval, no additional consents or HRC review was obtained. Due to pervasive weaknesses in the assessment process, it is likely that limited understanding of the individual's treatment targets is gained and only minimal support for intervention strategies can be provided. • One of 36 records reviewed (3%) included results obtained from a process or instrument recognized as being able to identify potential functions of a behavior. • None of 29 records reviewed (0%) reflected the use of more rigorous or empirical procedures necessary to clarify potential functions and address limitations inherent to indirect functional assessments. • In 36 of 36 records reviewed (100%), intervention targets were presented and monitored as a group regardless of differing function, topography or other characteristics. Without comprehensive assessment, and the resulting poor support for provided interventions, it is unlikely that the information contained in the consent and approval documents is valid, that treatments for which consent and approval have been requested can be supported, and that the those who have been requested to provide consent have been provided with adequate information upon which to base a decision. Specifically, informed consent requires that the consenter be provided with sufficient information about the proposed intervention to formulate a decision about whether or not to grant consent. In most situations, the consenter must be provided with the following information. • Implications of going without treatment and of treatment being postponed for different periods • The range of accessible diagnostic or treatment options • The benefits each option offers • The possibilities of diagnostic false results or treatment failures	

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		• The risks and discomforts of diagnostic or treatment options even when successful • Short-term injuries that diagnostic or treatment failures may cause • Long-term effects of diagnostic or treatment options, favorable and unfavorable, separating probabilities from possibilities It is the responsibility of the Facility to conduct the assessments essential for informed consent. Due to the limitations noted in the assessment and monitoring process, RGSC had consistently failed to meet the obligation of providing sufficient information to the consenter. As a result, the Facility consistently failed to obtain valid and informed consent.	
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.	Many Behavioral Services and other staff acknowledged substantial weaknesses in behavior data. Despite such concerns, there was not any routine assessment of the actual quality of behavior data. Except in isolated cases that were verbally reported, there was no attempt to measure data reliability or interobserver agreement (IOA). The Behavior Services department at DSSLC used spreadsheet software to compile treatment data and generate data graphs and progress notes. Although the data entered into this software were of questionable value, the software itself was sophisticated and useful. Most elements required in a data graph were present and the graphs were not overly complex. One weakness seen across all reviewed graphs was a lack of any indicators for changes relevant to monitoring behavioral progress. For example, if the dosage of a medication was changed or the individual was exposed to an environmental stressor, there was no indication on the graph of when the event occurred. Without such indicators, it was very difficult to identify the relationship between behavior, treatment effects and confounding variables. The same limitation was also noted on PBSP progress notes and the data graphs supplied for the monthly review of psychotropic medications. An additional limitation that was evident on these printed graphs involved differing alignment when comparing the data graph and the data table typically presented immediately below the graph. In numerous records reviewed, the interval for which there was a data point in the graph did not directly correspond with the interval in the table column immediately below. For example, a graph might include a data point representing 13 displays of pica during April, but the table column immediately below the data point included data for February. Although this was a rather subtle difference, it could lead to a misinterpretation of response to treatment. Compounding this issue was the inclusion of psychotropic drug dosages in the tables without any demarcation of drug dosage changes on the graphs. It	N

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		was easy to mistakenly perceive that a drug dosage change had taken place in one month when in fact the change had been implemented two or more months earlier. Inclusion of treatment condition change lines on the graphs would alleviate this problem is reduce the probability of misinterpreting the individual's response to treatment.	
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.	Observations of and interviews with direct support staff reflected that many staff had difficulties in understanding and/or implementing behavior interventions. In some cases, the difficulties related to the technical or complex language used in the intervention plan. In other circumstances staff reported that the layout and organization of the plans made it difficult to read and implement them as intended. • Individual #91 was observed to be shouting in a room adjacent to the dining room during the evening meal. Staff indicated that this was the individual's preference when other environments became too noisy but could not describe the specific contents of the individual's PBSP. No data were collected during the observation. • Individual #298 was observed sitting in his wheel chair with a yellow bandana tied around his head and crossing through his mouth. The bandana was saturated with saliva. The direct care staff present in the room reported that the bandana was part of a program to prevent the individual from chewing on and saturating his shirt. The staff in question could provide no further details about the program and was unable to state how often the bandana should be changed or who was responsible for checking or changing the bandana. This individual was used as a model for one of the posters in the Facility Administration Building promoting independence and choice. In the poster, he had a clean, dry bandana tied loosely across his upper chest. At the time of the site visit, DSSLC did not routinely assess the implementation of PBSPs. It is well understood that the application of any process will drift over time. Without ongoing training and assessment of intervention integrity, it will not be possible for DSSLC to ensure that PBSPs are being implemented as intended and in a manner that is of benefit to the individual. A comprehensive system of treatment integrity checks and staff training must be implemented in order to meet the Settlement Agreement.	N
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the	As was documented during the baseline site visit at DSSLC, the Facility did not employ a competency-based approach to staff training. In the majority of cases, training on PBSPs and other intervention related to behavior and mental health needs consisted of a verbal presentation of material followed by a brief assessment of knowledge. As a result, although documentation and staff reports supported that staff were provided with information concerning PBSPs, it was not demonstrated that staff had developed competence regarding the implementation of any PBSPs. This was confirmed by	N

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	overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	observation of one training session in which a psychologist implemented some aspects of competency-based training, including describing the interventions, demonstrating some interventions, and providing rationales but did not ask the DCP being trained to demonstrate how to implement the interventions. The majority of records reviewed reflected that training on PBSPs was typically conducted only when the PBSP was first implemented. This was also supported by staff statements and written reports. Only 2 of 36 (6%) of records reviewed included reference to follow-up or on-going efforts to train staff regarding PBSPs beyond the initial implementation period. At the time of the site visit, based upon record reviews and statements of staff, the Facility had not developed or implemented a system to ensure that pulled or relief staff were provided with training on PBSPs. Isolated cases were found, such as the classrooms located at residence 524, where supervisory staff strongly encouraged pulled or relief staff to review PBSPs and other programs and the beginning of their shift. Based upon the information acquired during the site visit, it is evident that the Facility has not yet met the requirement of providing competency-based training regarding PBSPs.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	At the time of the site visit, DSSLC employed 5 staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every individual residing at the Facility and fell far short of the required ratio of one BCBA for every 30 individuals. Even when all staff currently working toward BCBA credentialing have earned board certification, the Facility will not have met the requirements of this provision. In consideration of the fact that acquiring board certification can require up to three years, aggressive efforts will be needed to increase the number of employed BCBAs within the time stipulations provided under the Settlement Agreement.	N

Recommendations:

1. DSSLC needs to develop standards and procedures to identify when psychological services other than PBSPs are appropriate, how those services will be provided, what curricula or standard therapeutic procedures will be used, how fidelity of implementing those procedures by clinicians will be assessed, and how treatment effectiveness will be evaluated.
2. DSSLC should develop a system that monitors the outcome of the peer review processes. Peer review should produce meaningful and measurable improvement in the content, implementation and efficacy of interventions addressing undesired behavior or the symptoms of mental illness.
3. DSSLC must improve data collection, including IOA. The Facility should consider conducting an audit of the resources needed to ensure adequate data collection. The facility should then develop a system to ensure that sufficient resources are allocated to the data collection process.
4. DSSLC should develop and implement a system for ensuring that staff possess and use the skills necessary for formal and informal behavior

intervention. This includes developing competence in the basics of applied behavior analysis, as well as knowledge of and the ability to implement PBSPs correctly. It is recommended that training be competence-based and that staff assessment and training be conducted on an ongoing basis.

5. DSSLC must establish standards for psychological assessments, as well as a system to monitor adherence to those standards. These standards should include parameters for how often standardized assessments should be conducted, as well as the structure and content of a psychological assessment.
6. DSSLC must ensure that assessment of behavior includes all factors potentially relating to the targeted behavior. Many of the reviewed records did not include a comprehensive assessment of mental illness, the behavioral correlates to mental illness symptoms and differentiating between biological and environmental contributors to behavior displays.
7. DSSLC must ensure that the consent and approval process for restrictive procedures reflects true informed consent. All consent and approval submissions must reflect the latest revisions to the entire intervention strategy. In addition, the Facility must ensure that the intervention for which consent and approval is requested involves adequate assessment and reflects the least restrictive treatment option that has a reasonable probability of success.
8. Although data graphs have several positive features, it remained difficult in many cases to identify when treatment conditions changed. DSSLC must take steps to ensure that data graphs contribute to the monitoring of treatment success.
9. DSSLC must act to ensure that PBSPs can be easily understood by those staff expected to implement the programs. Many factors affect program implementation, including staff academic history, reading ability, and fluency in English, as well as how easily the program can be reviewed during a severe behavior display or by a new employee who must review information quickly at the beginning of the work period. All of these factors must be addressed to ensure the PBSPs are implemented correctly.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Denton Plan of Improvement (POI) 5/17/10 2. Denton Supplemental Plan of Improvement (SPOI) 7/6/10 3. The following clinical records of individuals #336, #575, #772, #342, #419, #594, #151, #411, #329, #655, #129, #620, were reviewed: a. Annual physical physical development and health evaluation b. Active problem lists c. Annual personal support plans d. Quarterly pharmacy reviews e. Annual pharmacy reviews f. Clinical progress notes g. Hospital transfer records h. Medication administration records i. Addendums to personal support plans j. Policies and procedures for peer review k. Policies and procedures for investigation of unusual events l. Laboratory results m. Diagnostic imagine reports n. Hospitalization reports o. Consultation reports p. Clinical and administrative mortality reviews q. Mortality review form r. Physical therapy reports s. Active clinical records t. Health Risk Screening tool 4. Documents related to hospitalization for individual #514, including the following: a. Death report b. Hospital laboratory studies c. X-ray's d. Physician and nurses progress notes e. Admission summary **People Interviewed:** 1. Brian Jacobs, LVN 2. Stephanie Stine, RN 3. Steven Kubala, M.D., Medical Director 4. Rosha Chadwick, R.Ph., Director of Pharmacy Services **Meeting Attended/Observations:** 1. Incident management meeting 9/28/2010

	2. Physical and nutritional management team meeting 9/30/2010 3. Review of significant event meeting 9/30/2010 4. Personal support plan meeting 5. Observations of individuals in several homes.
	Facility Self-Assessment: The Facility acknowledges that they continue to make significant strides in becoming compliant with Provision L. For example, the Facility reported that a medical providers workgroup and a nursing workgroup are developing a system to improve documentation in a number of areas, including hospital transfer and course, integrated progress notes, and communication with the interdisciplinary team. However, the Facility recognized that at the time of the on-site review they remain out of compliance with provisions L1 through L4.
	Summary of Monitor's Assessment: The review team clearly recognizes the diligent and meaningful work conducted by the Facility in working towards compliance with provisions L1 through L4. Many important steps have been taken, including the recent hire of a new medical director, the pending hire of a physiatrist, establishing a physician to conduct clinical reviews, contracting with a hospitalist, enhancement of the peer review and quality review process, enhancement of the risk assessment tool, and significant improvement improvements with integration of clinical services with the team process. These are the cornerstones of developing a quality health care delivery system that can lead to full compliance of the settlement agreement, specific to provision L1 through L4. As outlined by the report, much work is still required by the Facility. It is most important that all efforts developed by the facility directly translate to quality outcomes for all individuals who reside at the Facility. Subsequent reviews will focus not only the clinical process but on actual outcomes based on observational assessments of individuals Of significant issue is the number of deaths noted at the Facility. It was reported that there were 29 deaths at the Facility since October of 2009, which indicates a mortality rate of 50.6, based on an average censes of 573 individuals. When compared with the published mortality rate for people with developmental disabilities who reside at developmental centers of 11.7, and the "total" mortality rate of the United States (including infant and geriatric) of 8.4, Denton's rate was over four times that of the expected norm for developmental centers, based on published data (from Mortality in persons with DD after transfer into community care. Alfred Baumeister, American Journal on Mental Retardation, 1998, 102(6), 569-581, and CIA World Fact Book, 2010, Expected rate for individuals who reside in Facilities (1):11.7). The absolute rate may or may not be justified, however, the mortality review process at the Facility did not provide the analysis necessary to address deaths and develop actions to improve health care, let alone to identify and respond to this apparent high mortality rate.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two	The monitoring team reviewed clinical records and observed individuals at various homes. Following the review, it was evident that the Facility remained non-compliant with provision L1. It is important that the Facility ensure that not only are appropriate	N

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	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.	policies, procedures, and documentation at the level of standard of care but that clinical services translate to quality of care at the level of each individual. To delineate this issue, the review team conducted a comprehensive assessment of care of individual #514 that included review of current and historic clinical records and hospital reports. This case highlights significant system and clinical practice issues across the spectrum of health care delivery at the Facility. The following is a summary of concerns, specific to this case. It should be noted, however, that this example is used to highlight details that were evident and pervasive throughout the Facility, as noted by the number of aspiration cases, hospital admissions for pneumonia, the common occurrence of emesis with little or no follow-up, and the significant lack of a meaningful physical therapy program at the Facility. 1. The individual arrived at the center with the ability to ambulate and did not require significant support for ambulation. Ultimately, the individual lost significant functional ability with regards to ambulation and required a wheel chair. There was nowhere in the clinical records or the personal support plan, provided to the review team, that demonstrated an understanding of the individual's loss of function; specific diagnosis for the individual's condition; or specific treatment, maintenance therapy or monitoring for physical disability. 2. The individual was diagnosed with degenerative spine disease, and compression fractures of the spine were noted on imaging reports. There was no integrated process involved in the management or follow-up of this condition. Importantly, there was no evidence to support assertive clinical management, such as diagnostics (e.g., MRI of the spine), consultations (such as neurology, neurosurgery, orthopedic spine), or meaningful physical therapy assessment or treatments. Severe pain and discomfort commonly accompany degenerative spine and compression fractures; this was not addressed by the clinical team or the team process. Importantly, staff were not informed or trained on how to support the person for this serious condition. Under-treatment of degenerative spine disease may lead to worsening disability, intractable pain, and possible death. 3. Osteoarthitis was a known diagnosis and is a condition that can manifest severe pain and discomfort. Osteoarthritis may progress to worsening disability and loss of function. This issue was not assertively managed by the clinical staff, nor was there follow-up by the team process. 4. In the past the individual was diagnosed with anemia and provided B12 therapy. Subsequently B12 was discontinued and the individual was provided a	

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		multivitamin and iron supplement for her anemia. Based on records reviewed the clinical records were void of a comprehensive evaluation of the anemia and its etiology is unclear. If the individual was deficient in B12 and, or folic acid, pernicious anemia may have been diagnosed and specific therapy required life long. Untreated, B12 and, or folic acid deficiency may lead to serious neurological condition, including dementia and sensory dysfunction that can affect ambulation. If the person was not iron deficient, iron supplementation was not warranted and could result in iron overload. 5. The individual was diagnosed and treated for congestive heart failure; however, the clinical records reviewed were void of a comprehensive evaluation that would substantiate such diagnosis. In fact, multiple chest x-rays demonstrated normal lung findings, multiple EKGs were noted as unremarkable and without an axis shift, lung fields were auscultated by nursing staff on many occasions and were without characteristic signs of congestive heart failure, an echo-cardiogram and carotid Doppler were obtained in 2005 with normal results, and a repeat echo-cardiogram completed at the time of her last hospitalization did not demonstrate congestive heart failure. The individual carried the diagnosis of dependent edema of the lower extremities for many years. In this example, not only is the diagnosis questionable, neither the personal support team, nor direct care staff were not fully aware of the significance of this diagnosis if, in fact, the diagnosis was accurate. 6. The individual was known to have a diagnosis and was treated with medications for constipation. The individual was provided with fiber supplementation on a regular basis. There were no orders or clinical follow-up to ensure the efficacy of the use of fiber, to ensure that "adequate" hydration occurred daily and to ensure that there was no fiber-drug interaction. Fiber can bind many medications and alter their absorption. Most importantly, fiber supplements administered to individuals who have limited mobility, bowel dysmotility and possibly inadequate fluid intake(which would require monitoring in this case) may result in worsening constipation, obstruction and possible perforation. 7. The individual had a diagnosis of diverticulosis, which is a serious medical condition of the colon that can result in pain, discomfort, serious infection, and perforation of the colon. Ongoing clinical monitoring for this condition was warranted in this case. This condition should have been routinely assessed and well understood by the personal support team and well integrated in the personal support plan. 8. Edema of lower extremities was diagnosed many years ago as dependent edema	

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		secondary to immobility. Worsening edema of the lower extremities was noted in the clinical record and its etiology was less clearly delineated. Importantly, the individual was prescribed and administered Norvasc for hypertension. Norvasc is a drug that that is known to cause and exacerbate edema. The records reviewed did not entertain the possibility of Norvasc either causing or hastening the individual's edema. Given the severity and chronicity of the edema, either a definitive diagnosis or at a minimum and differential diagnosis should have been made following a comprehensive assessment of the edema and the issue clearly delineated within the individuals ISP. 9. Nursing assessments were noted to be inconsistent and incorrect. The nursing assessment did not address bowel elimination or muscle tone, which would be important and required assessments for this individual. There were significant inconsistencies with regards to the individual's cognitive state and abilities. In one section of the assessment, the nurse determined that the individual had "no impairment of communication or sensation" and that the individual was "verbal, " as well as that the individual had awareness of self and environment, while in a different section of the assessment the nurse reported that he/she was unable to assess all levels of orientation because the individual had impairment with cognition or was non-verbal. Nursing assessment reported that the individual had "slight" limitation with mobility in one section, albeit in another section, it was reported that the individual was non-mobile. 10. The individual was reported to have experienced a transient ischemic attack in March of 2005. The individual did undergo a carotid Doppler study, which was reported as normal but no additional follow-up or diagnostics (such as a magnetic resonance angiogram) were ordered. Importantly, this issue was not longitudinally addressed through the team process, nor was staff made aware to monitor for signs and symptoms of recurrence. A CT scan of the head was completed during the individual's last hospitalization, which demonstrated significant signs for occipital stroke, which may have resulted in the person's worsening ability to ambulate and at least moderate ischemic changes of the brain. 11. On January 7th and January 17th of 2010 the individual was evaluated for possible Pica secondary to finding the waist band of the individual's underwear in her mouth. It was presumed by the PST that once the underwear was changed to "cloth diapers, " no further monitoring would be necessary. It was also determined by the attending physician that no "xray" would be needed to assess bowel status. Pica and Pica-like conditions are serious and must always be	

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		considered potentially life threatening. The medical follow-up of suspected foreign body ingestion must be assertive. Specific imaging studies, with appropriate contrast agents, careful and prolonged monitoring of bowel elimination to assess for foreign bodies and prolonged monitoring of bowel function is critical. 12. The individual was prescribed a 1000 calorie restricted diet. The etiology of the individual's weight gain was not assessed adequately. Given the state of worsening edema, the issue of fluid retention for her weight gain should have been considered. Regardless, a 1000 calorie restricted diet is extreme and should have been well reviewed by the personal support team, and a rational differential diagnosis as to the etiology documented in the clinical record. 13. The individual expired on the same day as hospitalization. During the evening prior to, and early morning hours before the hospitalization, the individual experienced three reported episodes of emesis and a large amount of "brown liquid" was found in the bed. At approximately 0626 on the morning of hospital, the individual experienced a fourth episode of emesis. At this time the individual was reported not to be in respiratory distress and had normal vital signs, however, the abdomen was firm, and bowel sounds were sluggish in all quadrants. The nurse had the individual returned to bed and performed a rectal examination, which demonstrated hard pebble like stool in the rectal vault and she administered dulcolax suppository. The nurse then requested DCPs to report any emesis or change in status. At approximately 7:25, the nurse assessed the individual and noted that the individuals was experiencing wheezing on inspiration, grunting with respirations, was lethargic and diaphoretic. The physician was then notified and instruction to hospitalize the individual was given. Per review of hospital records that were provided to the review team, the individual was in critical condition upon admission and required artificial ventilation. Several important findings were noted within the reviewed hospital records that included: The individual had a normal white blood cell count; CT of the brain without contrast noted a large calcification on the left occipital lobe and atherosclorosis of the vessels; Chest x-ray at approximately 8:32 demonstrated a possible left pleural effusion and a left infiltrate or atelectasis of the left lobe and that the endotrach tube was placed in the right bronchus; repeat chest x-ray at approximately at approximately 0900 showed improvement with atelectasis and moderate gas distention of the colon; an echo cardiogram was completed and demonstrated an ejection fraction of 75%; nasogastric tube was placed at approximately 0910 on the morning of admission that was reported to be in proper position per nursing assessment;	

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		pulmonology consultation assessed acute respiratory failure with left pneumonia or atelectasis with aspiration as a possibility and hypotension secondary to intubation or possible sepsis; xray to assess PICC line was completed at 1444 that demonstrated mild stable base atelectasis or infiltrate and that the nasogastric tube was coiled in the middle esophagus, which necessitated the radiologist to immediately notify nursing staff at 1450 and that the PICC line was in the right atrium with the PICC nurse being notified at 1445; hospital nursing notes reviewed indicated that the PICC line was repositioned, however, the review team did not identify documentation to indicate that the nasogastric tube was repositioned by nursing staff (the individual was reported to be NPO, however, prn oral medications were prescribed); during the hospitalization, according to the documents reviewed and given the individual's history of emesis and noted "brown" and "green" fluid upon NG suction, there was no formal assessment of bowel function per diagnostics such as x-rays, CT or US examination or formal assessment by a gastroenterologist. An autopsy was not completed and the medical examiner determined that the case was not deemed necessary for review by their office. Upon review of the events leading to hospitalization, documents provided regarding hospitalization, the reported cause of death and the Facilities clinical review of the case, the monitoring team expresses significant concern that includes: a. Third shift nursing staff were aware of at least three episodes of emesis and "brown liquid" in the bed of the individual and did not notify the physician on call. b. The first shift nursing staff was aware of three episodes of emesis and following an additional episode of emesis and an abnormal abdominal assessment, had the individual placed back in bed to assess for constipation and, as the previous nurse, did not notify the physician of emesis, abnormal nursing assessment or additional episode of emesis. Importantly, the nurse did not place the individual back into the recliner, per recommendations of the previous nurse, but kept the individual in bed and instructed staff to monitor for additional episodes of emesis. c. Possible issues at the hospital, including the malposition of the nasogastric tube, and the possibility of their nursing staff not attending to this issue, are of potentially critical significance, as is the reported cause of death being secondary to "pneumonia. " These issues should have been reviewed by the Facility's clinical staff and pending a more	

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		detailed review, possibly been discussed with the treating hospital. d. Clinical findings per diagnostics at the hospital, including a normal echo cardiogram and abnormal CT of the brain, should have been well reviewed by the Facility's medical staff in the context of a medical review of the diagnosis of congestive heart failure and the remote diagnosis of a TIA. Such a review could point out the need to establish procedures at the Facility to ensure diagnoses are well-supported (as the diagnosis of congestive heart failure had continued without such support) and, if not, that additional efforts are made to ensure accurate diagnosis. The clinical presentation of this individual, which included abnormal abdominal assessment per the Facility's nursing staff, at least four episodes of emesis, brown liquid found in the bed of the individual at the Facility and brown nasogastric fluid noted at the hospital, suggests the possibility of an acute abdomen and possible obstruction, partial obstruction and/or gastrointestinal bleed. This issue should have been well explored through the clinical review process at the Facility. Importantly, the prolonged use of fiber supplement in an non-ambulatory individual without close monitoring of fluid intake and a history of possible ingestion of foreign bodies without assertive clinical assessment, such as contrast imaging studies, should have been reviewed through the clinical review process. In general terms, clinical documentation was limited at best. Important clinical issues were not regularly documented by the physician. Outside of the annual clinical assessment, there are scant physician notes regarding health care issues and follow-up. In general, clinical records at the facility were not user friendly and at times obstructed the delivery of care. A review of the health risk screening tool was conducted, along with the Facility's Medical Director, Dr. Kubala. The Facility, under the leadership of Dr. Kubala, was currently revising the health risk screening tool to making it more clinically sound by incorporating evidence based criteria to the clinical decision rationale of the tool. The Facility was working diligently with Central Office to standardize and enhance the risk assessment tool. While reviewing hospitalizations, the monitoring team was made aware that the Facility had recently contracted with a hospitalist who will work directly with the Facility on any hospital transfer case. This effort has the potential of significantly improving outcomes, as they relate to hospitalizations. Review of current hospital records indicated a lack of	

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		continuity of care when individuals were transferred to the hospital, during their hospitalization and upon return to the Facility. Specifically, the Facility did not adequately review hospital records nor assertively monitor hospitalizations of individuals served by the Facility. Full integration of clinical services into the team process remained an issue for the Facility. The Facility had made significant strides towards integrating the process, teams had been better defined, and meetings were conducted; however, the efficacy and efficiency of the team process requires refining. The PSP meeting to discuss individual #342 demonstrated a lack of coordinated effort by the team members, minimal leadership by clinical professionals, lack of needed input by the psychiatrist and significant challenges with summarizing and prioritizing recommendations.	
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.	The Facility had been diligently addressing the issue of medical reviews by non-Facility physicians as well as improving their internal reviews of their clinical practice. The Administration, including the Medical Director and Superintendent, continued to strive to enhance and improve upon their recent efforts of the peer review process, which currently consisted of an external physician from an alternate developmental facility within the State system, reviewing identified cases known to be of a significant nature. The Facility recognized that review must be more broad and consist of periodic review of physicians' practice in general. The Facility was exploring mechanisms to ensure that the review process that assures physicians' practice complies with the Facility's policies and procedures, as well as recognized standard of care practice.	N
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.	The Facility, under the leadership of the Facility's Director, developed and implemented the initial mechanism of a medical improvement process by which clinical indicators were identified and assessed longitudinally. The Facility recognized that the current process did not yet bring the Facility into compliance with provision L1 and was continuing to improve on their process by developing mechanisms to enhance data collection and ensure that relevant data are collected and that the process actually extends to the level of individuals served, thereby ensuring that quality improvement efforts actually translate to meaningful outcomes, over extended periods of time. Review of the mortality review process, specific to the clinical component indicated the need for significant improvement. There was significant evidence to indicate a lack of comprehensive review and limited conclusions with regards to the death and the delivery of care prior to the death. Importantly, meaningful clinical recommendations and follow-up on recommendations was found to be problematic. Of significant issue is the number of deaths noted at the Facility. It was reported that there were 29 deaths at the Facility since October of 2009, which indicates a mortality rate of 50.6, based on an	N

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		average censes of 573 individuals. When compared with the published mortality rate for people with developmental disabilities who reside at developmental centers of 11.7, and the "total" mortality rate of the United States (including infant and geriatric) of 8.4, Denton's rate was over four times that of the expected norm for developmental centers, based on published data (from Mortality in persons with DD after transfer into community care. Alfred Baumeister, American Journal on Mental Retardation, 1998, 102(6), 569-581, and CIA World Fact Book, 2010, Expected rate for individuals who reside in Facilities (1):11.7). The absolute rate may or may not be justified, however, the mortality review process at the Facility did not provide the analysis necessary to address deaths and develop actions to improve health care, let alone to identify and respond to this apparent high mortality rate.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	In general, the Facility identified the need to enhance clinical services and outcomes of individuals served by the Facility. The recent hiring of the new Medical Director has brought clinical expertise to the Center that in time can enable the delivery of high quality health care to all individuals served by the Facility. At the time of the on-site review, the Medical Director was reviewing the Facility's current policies and procedures, as well as working with Central Office on new policies and procedures specific to standard of care practice (specifically the high risk screening tool). Following discussion with the Medical Director it was evident that the Facility is highly motivated to begin the process of updating and developing meaningful standard of care practices, At the time of the review, no new clinical policies or procedures, specific to clinical care were available for review.	N

Recommendations:

1. When enhancing the current peer review process, it is important that a random selection is included in the review process and that review is done of the physicians' actual clinical practice, including physical examination, clinical skills, documentation practice, ability to follow-up on issues through resolution, clinical management of chronic and acute health care conditions, and knowledge and understanding of general and specific clinical issues as related to developmental medicine, and adherence to the Facilities policies and procedures. Most important, the review process must ensure positive outcomes for persons served.
2. Quality assurance measures must be comprehensive. The process must ensure that common and serious issues such as aspiration pneumonia; infectious disease issues such as influenza; multiple drug resistant organisms; gastrointestinal conditions such as constipation, obstruction and perforation; and neuromuscular conditions are assessed regularly. Other issues such as, fractures and serious and common traumatic injuries, causes of hospitalization and death are examples of other issues that should regularly be assessed through a meaningful review process that

actually translates to enhanced care and positive outcomes for persons served. The quality assurance process must ensure that recommendations actually translate to quality care for individuals served, hence, once recommendations through quality assurance efforts are formulated and implemented, regular review of individual cases will be necessary to ensure efficacy of the recommendations.

3. When enhancing and developing new health care policies, it is important to consider the unique needs of individuals with developmental disabilities and not simply incorporate practice standards that are specific for the general population. Issues such as compliance on the part of the person served, challenges posed by certain physical and intellectual disabilities, such as the inability to self report sings and symptoms of illness or side effects to medications and anatomical variances common to people with intellectual and physical disabilities must always be taken into consideration when developing and implementing clinical policies.
4. The Facility should consider a comprehensive review and updating of the health care issues of each individual who resides at the Facility ..
5. Review of physical therapy reports and the roster of individuals who require physical therapy services with the review teams observational assessment of individuals served by the Facility clearly indicate the need for enhanced physical therapy services, as well as a more robust identification of individuals who require treatment for serious musculoskeletal and neuromuscular conditions. The recent hire of a physiatrist will no doubt improve clinical outcomes, however, the Facility must recognize the important ramification of under treated musculoskeletal and neuromotor conditions and ensure that those requiring treatment and long term management receive appropriate services. Specifically, all cases of "functional decline" must be assertively addressed – in general terms, if an individual could ambulate in the past, and for some reason is currently not ambulating or ambulating as well, must be comprehensively assessed, appropriately treated and closely monitored.
6. Throughout the review process and per discussion with the Medical Director, it was evident that clinical documentation practice and clinical records themselves were inefficient and ineffective. Improvements in health care will not be possible without a robust medical record process. When identifying an electronic health care record system, it is important to ensure that the record system will specifically manage "medical" applications. A Federally certified "EHR" that is HL7 compatible, HIPAA compliant and medical-legally sound should be set as a priority. The Facility and, or the system may need to consider two "EHR" systems, one specific for Medical applications and a separate system, albeit compatible with each other (i.e ability to share data and reports) that is specific for habilitation applications may be the most effective and efficient route.
7. It is imperative that the Facility gain a better understanding of the common, serious and unique clinical issues as they relate to individuals with intellectual and physical disabilities, especially in the area of aspiration pneumonia, communicable disease, gastrointestinal conditions and musculoskeletal/neuromotor conditions.
8. When assessing clinical issues, it is imperative to continue the evaluation through to the root cause of any condition hence, determining the etiology of a condition is paramount. For example, if an individual is diagnosed with aspiration pneumonia, the etiology of the aspiration pneumonia is extremely important, thus a definitive treatment for the aspiration can be provided, hence, minimizing or alleviating recurrence. Also, if someone develops swallowing difficulties, it is imperative to determine the cause.
9. During the review team's assessment of the morbidity and mortality review process, it was evident that current process be significantly enhanced. More frank discussion and intense review of cases with "meaningful" recommendations specific to clinical activity must be developed. Longitudinal data analysis is also needed in the mortality review process. The Facility and system will never improve without an effective method to review adverse outcomes.
10. Current efforts towards enhancing the high risk screening tool are commendable.
11. When enhancing the review process of hospitalized individuals, it is advantageous to ensure that a robust monitoring system of daily events at the hospital be reviewed by the medical staff and that adequate liaison with hospital nursing and medical staff takes place daily. It is important that the treating hospital be well informed of the individual's health care issues. Importantly, all hospital records must be reviewed by the Facilities medical staff and all relevant diagnostics, therapies and consultations be incorporated into the individuals health care plan, as necessary.

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Plan of Improvement, (POI) 5/17/10 2. DSSLC Supplemental Plan of Improvement (SPOI), 7/6/10 3. DSSLC Records Reviewed for Individuals: #715, #769, #581, #409, #326, #214, #595, #337, #616, #517, #342, #776, #36, #276, #496, #228, #206, #218, 298, #93, #381, #590, #419, #32, #746, #485, #685, #638, #433, #621, #443, #285, #107, #365, #519, #534, and #198 4. DSSLC Skin Integrity Meeting Minutes, 9/8/10 5. DSSLC Indicator 2.7 – Decubitus Quarterly Totals, September, 2009, through August, 2010 6. DSSLC Tracking Decubitus Report, 6/1/10 through 9/8/10 7. DSSLC Tracking Decubitus Report – Unresolved, 5/14/10 through 6/1/10 8. DSSLC Division of Nursing, Acute Illnesses and Injuries Policy and Procedure, Reviewed/Revision Date: July 2009 9. DSSLC Division of Nursing, Clinic List Policy and Procedure, Reviewed/Revision Date: 4/1/09 10. DSSLC Health Care Protocol - Health Management Plan – Vomiting 11. DSSLC Control Drug Sheets and Equipment Checklists, 8/30/10 through 9/25/10 12. DSSLC Daily Infirmary Crash Cart Checklists, 9/1/10 through 9/30/10 13. DSSLC Post-Care Progress Note for Triage after hospital/ER Discharge Form 14. Texas Department of Aging and Disability Services, State Supported Living Centers Policy, Nursing Protocol: Post Anesthesia Care, Date: June 2010 15. DSSLC Pre/Active/Post Sedation Checklist Form 16. DSSLC Infirmary Discharge/Triage Nursing Assessment Form 17. DSSLC Desensitization Workgroup Notes and List of Top 20 Individuals – Non-compliant with Dental Cleaning, Require Sedation, 9/20/10 18. SBARS (Situation, Background, Assessment, Recommendations, and Summary) Report to a Physician Poster 19. Texas Department of Aging and Disability Services, DSSLC Policy CMGMT-01, Protection from Harm – Abuse, Neglect, and Incident Management, Date: 2/24/10 20. DSSLC Positive Behavior Support Limitation of Restraint as a Crisis Intervention, Policy and Procedure CMGMT-20, Date: 11/9/09 21. DSSLC Medication Administration Observation Form, Revised: 4/20/10 22. DSSLC 10 PM to 6 AM Nursing Staffing Information 23. DSSLC E-Mail from Delia Schilder, Chief Nurse Executive, Regarding Notifying Providers of Acute Illness, 9/28/10 at 9:17 a.m. 24. DSSLC E-Mail from Delia Schilder, Chief Nurse Executive, regarding Individual #514's death, 9/29/10 at 9:00 a.m. 25. DSSLC Emergency Room Report, 4/1/10 through 9/27/10 26. DSSLC Hospital Admissions Report, 4/1/10 through 9/27/10 27. DSSLC Infirmary Visits Since 1/1/10

	28. DSSLC Medical – 08, Life Sustaining Treatment Policy and Procedure, Date: 10/22/10 29. DSSLC Residents Currently on Leave, - Hospital List, 9/29/10 30. DSSLC Admission Activity (All Admissions), 3/1/10 through 8/12/10 31. DSSLC Report for Monitors, 9/27/10 32. DSSLC QA/QI Meeting: Data Analysis Report, 9/23/10 33. DSSLC QA Monitoring Schedule 34. DSSLC Nursing Assignments for Monitoring using Settlement Agreement Monitoring Tools., Revised: 6/11/10 35. DSSLC Position Description for Safety Specialist 36. DSSLC Safety and Security Operating Instructions; Section 15, Emergency/333 Calls, Page 5 37. Texas Department of Aging and Disability Services, State Supported Living Centers Policy: Medical Emergency Response, Policy Number: 044, Date: 7/21/10: a. Medical Emergency Drill Checklist b. Emergency Competency Checklist 38. DSSLC Emergency Equipment Checklist for All Units, September, 2010 39. DSSLC Competency Training Development, Course Delinquency Lists for Cardiopulmonary Resuscitation (CPR) and Emergency Response, 9/2/10 40. DSSLC Automatic External Defibrillator (AED), Oxygen, and Suction Machine Location List 41. Texas Department of Aging and Disability Services, State Supported Living Centers Procedure: Nurse Competency Based Training Curriculum, Date: August, 2010 42. Texas Department of Aging and Disability Services, State Supported Living Centers Procedure: Care Plan Development: July, 2010 43. DSSLC Nursing Services: In-service Training for AED use 44. DSSLC General Nursing Orientation Schedule 45. DSSLC Nursing Services: Health Fair Schedule for Competency-based Skills 46. DSSLC Aspiration Pneumonia Clinical Protocol – House-Wide Clinical Protocol, Reviewed/Revision Date: October, 2009 47. DSSLC Pneumonia Committee Meeting Minutes, 4/22/10 and 9/17/10 48. DSSLC Pneumonia Root Cause Analysis, 5/14/10 49. DSSLC Memory Jogger: Preventing Aspiration Pneumonia Poster 50. DSSLC List Individuals in Suction Toothbrushing Pilot 51. DSSLC PICA Audit Tool, 9/23/10 52. DSSLC Memorandum, 8/24/10, from Delia Schilder, Chief Burse Executive and Nancy Condon, Director to Chris Adams, Assistant Commission, SSLC and Valerie Kipfer, Nursing Coordinator, Re: Proposed Plan to fill Open Nursing Positions 53. Texas Department of Aging and Disability Services, State Supported Living Centers Procedure: Guidelines for Comprehensive Nursing Assessment, Date: July, 2010, and Comprehensive Nursing Assessment Form 54. Texas Department of Aging and Disability Services, State Supported Living Centers Procedure: Care Plan Development, Date: July, 2010 55. Texas Department of Aging and Disability Services, State Supported Living Centers Procedure: Nursing

	Competency Based Training Curriculum, Date: August, 2010 56. DSSLC PICA Audit Blank Tool, December 2009 57. DSSLC Division of Nursing, Competencies (Training Requirements), Reviewed/Revision Date: July, 2009 58. DSSLC Documentation Test – Nursing Skill Fair 59. DSSLC In-service: Fall Risk in Adults with Developmental Disabilities, Strategies in Fall Assessment, Intervention and Prevention, Webinar Training and Signed Training Roster, 4/30/10 60. DSSLC In-service: Physical Nutritional Management Team (PNMT): Identification of Risk and Development of Interventions and Competency-based Training Roster, 7/9/10 61. DSSLC Division of Nursing, G-Tubes and J-Tubes: Care of Enteral Feeding Tubes Procedures, Reviewed/Revision Date: March, 2009 62. DSSLC In-service: Seizures and Signed Training Roster, 9/17/10 63. DSSLC In-service: Vagal Nerve Stimulator (VNS) and Signed Training Roster, 7/6/10 64. DSSLC Meal Observation Blank Sheet 65. DSSLC Infection Control Reports for 1/1/10-through 3/31/10 and 4/1/10 through 6/30/10 66. DSSLC Communicable Diseases by: Select Code 57, Methicillin Resistant Staphylococcus Aureus (MRSA), Select Code 17 Hepatitis A and B, and Select Code 53 Clostridium Difficile (C-Diff) Reports, 1/1/10 through 8/31/10 67. DSSLC Tuberculin Positive Skin Test, 1/1/20 through 8/31/10 68. DSSLC Client Immunization Report, as of 8/31/10 69. DSSLC Division of Nursing, Medication Administration Policy, Review/Revision Date: February, 2010 70. DSSLC Medication Administration Observations – Completed by QA Nurse, March, 2010 through May, 2010 71. DSSLC Adverse Drug Reaction Reports, 8/12/10 and 8/19/10 72. DSSLC Medication Watch Poster 73. DSSLC Pharmacy and Therapeutics Committee Meeting Minutes, 4/28/10, 5/19/10, 6/23/10, and 7/26/10 74. DSSLC Medication Error Committee Minutes, 3/11/10, 3/26/10, 4/20/10, 6/11/10, 6/25/10, 7/9/10, 7/23/10, 7/30/10, and 8/13/10, 75. DSSLC Medication Errors – Corrective Action Taken Reports, 4/1/10 through 8/24/10 76. DSSLC Medication Error Reports for last 10 Medication Errors, 8/1/10 through 8/28/10 77. DSSLC Medication Error Trend Data 78. DSSLC Division of Nursing, Seizure Management Policy and Procedure, Date: None 79. DSSLC Immediate Care for a Seizing Resident Procedure, 1/21/10 80. DSSLC Nursing Meetings Minutes: a. Nurse Manager Meeting, 6/22/10 b. Nurse Case Managers Meetings, 2/23/10, 4/12/10, 5/24/10, 6/29/10, and 7/30/10 c. Cedar Falls and Houston Park Nurse Meetings, 4/22/10, 5/25/10, and 6/29/10 d. Eastfield and Timberhill Staff Nurse Meetings, 5/26/10, 6/29/10, 7/21/10, and 8/25/10 e. Garden Ridge and Westridge Nurse Meeting, 8/25/10 81. DSSLC List of Deaths, 1/6/10 through 8/4/10

	82. DSSLC Positive Support Plan (PSP) Due Dates **People Interviewed:** 1. Delia Schilder, RN, Chief Nurse Executive 2. Sherri Courtney, RN, Nurse Operation Officer (NOO) 3. Johnna Hayse, RN, Skin Integrity Nurse 4. Sibylle Gaviett, RN, Case Manager Supervisor 5. Donna Gidcumb, RN, Hospital Liaison Nurse 6. Jacqui Garrison, RN, Infection Control Nurse 7. Bob Carpus, RN, Infirmary Nurse Manager 8. Mathew Mathew, RN, Nurse Case Manager, Cedar Falls – 512B 9. Mary Harrison, RN, Nurse Case Manager, Cedar Falls - 502 10. Numerous Staff RNs/LVNs and Direct Support Staff 11. Rebecca Wilkins, Director of Quality Enhancement 12. Lori Powell, Settlement Agreement Coordinator 13. Chuck Brookins, Safety Officer 14. Randy Spence, M.S., Director of Behavioral Services 15. Patricia Artman, Program Specialist III 16. Rosha Chadwick, RPh, Director of Pharmacy **Meeting Attended/Observations:** 1. DSSLC Entrance Meeting, 9/27/10 2. DSSLC Tour of Living Units 3. Medication Administration Observations, in Houston Park, 515A and Timberhill, 508, 9/30/10 4. Critical Incident Meeting, 9/30/10 5. PNMT and PBSC Meeting, 9/30/10
	Facility Self-Assessment: DSSLC Plan of Improvement (POI) reported they were not in substantial compliance with multiple provisions and action steps listed in Section M (Nursing Care). The provisions listed as not in compliance included: • Provision M.1: DSSLC shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care. Monitoring teams concurs with the Facility based on observations, record and document reviews. Since July, 2010, the Nursing Department had adopted, implemented, and trained the nursing staff in numerous policies and procedures. However, nursing practice did not yet meet substantial compliance with this provision because not enough opportunities had occurred to demonstrate significant improvement in completing comprehensive nursing assessments and compliance with those policies and procedures. • Provision M.4: Within 12 months of the Effective Date (6/26/09), DSSLC shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served. The monitoring team concurs with the Facility based on observations, record and document reviews. Since July, 2010, the Nursing Department had adopted, implemented, and trained the nursing staff in numerous policies and procedures. However,

nursing practice did not yet meet substantial compliance with this provision because not enough time had elapsed to demonstrate significant improvement in completing comprehensive nursing assessments .

DSSLC POI reported they were in substantial compliance with some of the action steps contained in the following provisions:

- Provision M.2: Action Steps included:
  - A review of 100% of the records showed that the Facility's Annual Nursing Assessment Policy and procedures met current professional standards of care. The nursing process:
    - Provides a comprehensive overview of individuals' past and present health care status and needs;
    - Serves as a blueprint for nursing and other health care providers to plan and direct care to: promote, maintain and restore wellness; prevent illness and/or enhance the individuals' health status. Note: This is a systemic issue, not to be evaluated individually.

    The monitoring team concurs with the Facility's finding that the Annual Nursing Assessment Policy met substantial compliance. However, the Quarterly and Annual Nursing Assessments did not meet compliance. The recently revised Guidelines for Comprehensive Nursing Assessment and accompanying Form was implemented in August, 2010, and there were not enough examples to review since implementation for the nursing practice to meet substantial compliance with this provision.

  - A review of 100% of the records showed that there was documentation that Annual Nursing Reviews (Assessments) were:
    - Scheduled and documented reviews that assessed an individual's health status; and
    - Completed by the RN. The LPN may assist with gathering data for the review.

    The monitoring team concurs with the Facility's findings for this action step. All Annual and Quarterly Nursing Assessment were completed by RNs and completed according to the individuals' PSP schedule.
- Provision M.5: Action Steps included:
  - A review of 100% of the records showed that the Facility maintains a system for tracking infections, identifying outbreaks and other problematic trends, and takes action to address such trends.

  Monitoring team concurs with the Facility's findings for this action step based on review of the Infection Control data.
  - A review of 100% of the records showed that the Facility actively collects data with regard to infections and communicable diseases.

  The monitoring team concurs with the Facility's findings for this action step based on review of the Infection Control data.
  - A review of 100% of the records showed that there was a system in place that ensures the reliability of these data.

  The monitoring team did not concur with this action step because there was no evidence

	presented to demonstrate that Infection Control data were reliable. o A review of 100% of the records showed that the training curriculum and training rosters indicate that all staff were trained regarding hand washing practices in accordance with the Centers for Communicable Diseases (CDC) guidelines. The monitoring team could not concur with this action step because no training data for hand washing were made available for review as requested through the document request. o A review of 100% of the records showed that the training curriculum and training rosters indicate that all staff were trained regarding Standard Precautions. The monitoring team could not concur with action step because no Standard Precautions training data were made available for review as request through the document request. o A review of 100% of the records showed that the Infection Control Department and/or Pharmacy Department monitored the use of antibiotics. The monitoring team concurs with the Facility's findings on this action step based on review of Infection Control data regarding antibiotic usage. o A review of 100% of the records showed that individuals at risk for complications from influenza virus have been given the influenza vaccine annually with the current year's vaccine per current CDC protocol (except individuals known to have anaphylactic hypersensitivity to eggs or other vaccine components). The monitoring team concurs with the Facility's findings based on review of individuals' immunization records and the Infection Control Immunization Tracking Spreadsheet. o A review of 100% of the records showed that repeated Mantoux testing was conducted for tuberculin-negative individuals after any suspected exposure to a documented case of active tuberculosis according to the CDC and local Department of Health Guidelines. o A review of 100% of the records showed that individuals with chronic or recurrent respiratory problems were referred to a clinician with specialized expertise in pulmonary medicine. The monitoring team could not substantiate compliance with this action step because none of the individuals reviewed with chronic respiratory problems showed they were referred to a clinician with specialized expertise in pulmonary medicine. This action step would more appropriately be referred to in Section L. • Provision M.6: Action Steps included: o A review of 100% of the records showed that actions were taken (i.e., corrective action and follow-up) and noted on a medication error form and/or incident report form which corresponded to the severity and/or frequency of the error. The monitoring team concurs with the Facility's finding for this action step based on review of the Medication Administration Observation Tools. o A review of 100% of the records showed that the Narcotic Logs were appropriately signed to indicate that the narcotic count was conducted by the on-coming and off-going medication nurses. The monitoring team could not substantiate compliance of this action step because Medication Administration Observation was only completed in two units nor were copies of the Narcotic Logs made available for review as requested in the document request.

	o A review of 100% of the records and/or observations completed showed that the following occurred: ▪ Correct medications administered; ▪ Medication administered to the correct individual; ▪ Medication administered in the order form; ▪ Medications administered at the correct time; and ▪ Medications administered on the correct date. The monitoring team did not concur with this action step because review of MARs had blank blocks without initials or explanations.
	Summary of Monitor's Assessment: Provision M.1**:** The monitoring team did not find the Facility in compliance with this provision even though new policies and procedures were implemented and nursing staff trained since the baseline review. While some progress had been made with increasing nursing staffing, particularly on the night shift, and in other general areas of nursing practices; the Nursing department has room for improvement in documentation, assessment, and notification of physician of acute illness and injuries. It was a positive finding that the QA Department and Nursing Department had adopted, implemented, and trained the Nursing Leadership, Nurse Managers, and Case Managers in the Settlement Agreement Monitoring Tools. Audit completed by the nursing staff used a peer to peer process. Use of the Tools began in July, 2010, and the Facility had not had enough time to analyze data to use for corrective action. Provision M.2: The monitoring team did not find the Facility in compliance with this provision. Although the Nursing Department had adopted, implemented, and trained the RN Case Managers on the newly revised Guidelines for Comprehensive Nursing Assessment and accompanying form in August, 2010, not enough opportunities had occurred to demonstrate significant improvement in completing comprehensive nursing assessments for the monitoring team to find compliance. The implementation of the Comprehensive Nursing Assessment was a positive finding and, with experience, continued progress should be made toward compliance. Provision M.3: The monitoring team did not find the Facility in compliance with this provision. The Nursing Department had adopted, implemented, and trained the RN Case Managers and other nurses in August, 2010, on the Health Care Protocol for Developmental Disability Nurses to use for developing health care plans. However, not enough time had elapsed for the Facility to demonstrate significant improvement for compliance. The implementation of the Health Care Protocol for Developmental Disability Nurses was a positive finding and with experience continued progress should be made toward compliance. Provision M.4: The monitoring team did not find the Facility in compliance with this provision. Although numerous new policies and procedures have been developed, adopted, and implemented since the baseline review, the statewide nursing work group were continuing to develop other policies, procedures, and guideline to improve nursing practices and to ensure compliance with the Settlement Agreement and Health Care Guidelines. As more policies, procedures, and guidelines are developed and implemented, progressive improvements should be made toward compliance.

	Provision M.5: The monitoring team did not find the Facility in total compliance with this provision but concur with the Facility's finding of compliance with several action steps relating to Infection Control reporting and tracking data. Individuals' records reviewed for immunizations indicated they were up to date. It was positive that the Facility had self-initiated a Pneumonia Work Group to analyze causative factors contributing to incidences of all types of pneumonia with emphasis on aspiration pneumonia, and to develop and implement strategies to minimize the incidents of pneumonia. There remains much improvement to be made in preventing or control infectious disease process, particularly aspiration pneumonia and sepsis. Provision M.6: The monitoring team did not find the Facility in compliance with this provision. Significant progress had been made since the baseline review in an effort to improve medication administration practice and reduce or minimize the incidents of medication errors. However, the Facility did not have adequate space to provide privacy for individuals to receive medication, or freedom from distraction for the nurses which is needed to help reduce the potential for medication error, or facilities accessible for nurses to wash their hands. The Pharmacy's WORx system was problematic in printing the MARs with adequate information needed to provide the nurses administering medication with the complete instructions for the number of pills to make the prescribed dose and to safely administer medication. The Medication Error System of analyzing and trending medication error data was not easy to understand and needs to be revised so it can be clinically useful.

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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.	DSSLC reported in the Plan of Improvement (POI) that they were not in compliance with multiple actions steps in this provision. Since the baseline review, it was evident to the monitoring team through documents reviewed, staff interviews, and observation that the Nursing Department had put forth much effort toward achieving compliance with this provision. <u>Staffing</u> Since the baseline review in April, 2010, the Nursing Department had increased staffing and reduced the use of agency nurses. Agency nurses were only used when necessary to meet current minimum staffing ratios. At the baseline review there was a concern regarding the limited nursing staffing on the 10 p.m. to 6 a.m. shift. At the time of the review the Facility was providing services to 542 individuals. Nursing coverage on the 10 p.m. to 6 a.m. shift consisted of 11 to 12 staff nurses, one House Supervisor and one Nurse Manager. The breakdown of the staffing patterns by unit included: • Infirmary North Wing (serves 10 individuals) and South Wing (serves six possible individuals) for a total of 16 individuals had two staff nurses of which one must be a Registered Nurse (RN). • Cedar Falls (serves 89 individuals) and Houston Park (serves 75 individuals) for	N

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		a total of 164 individuals had three staff nurses, one RN Charge Nurse for Cedar Falls and one RN Charge Nurse for Houston Park. • West Ridge (serves 89 individuals) and Garden Ridge (serves 72 individuals) for a total of 161 individuals had two staff nurses of which one must be a RN. • Eastfield (serves 67 individuals), Timberhill (serves 69) and Pine Ridge (serves 71 individuals) for a total of 207 individuals had two staff nurses of which one must be a RN. The ratio was approximately one nurse for every 45 individuals, not including the House Supervisor and Nurse manager, but in reality there were areas that ranged from 54:1 to 103:1. Delia Schilder, Chief Nurse Executive (CNE), stated to provide for a safe complement of nursing staff on the 10 p.m. to 6 a.m. shift, the Nursing Department needed 14 additional staff nurses of which six needed to be RNs. The monitoring team understood this may be achieved through a plan for redistribution of nursing positions, as identified above, in addition to filling vacant positions. At the time of the review the Nursing Department's overall nursing positions included a total of 144.5 RN positions of which 98.5 were filled and 46 positions were vacant; and a total of 83 Licensed Vocational Nurses (LVNs) positions of which 80 positions were filled and three positions were vacant. The list below described the Nursing Department's staffing patterns: • Nursing Administrative Positions: o 1 Chief Nurse Executive o 1 Nurse Operation Officer o 1 RN Case Manager Supervisor o 1 Specialty Nurse Manager • Nurse Manager Positions: o 2 Unit Nurse Managers for Cedar Falls and Houston park o 2 Unit Nurse Managers for West Ridge and Garden Ridge (one vacant position) o 2 Unit Nurse Managers for Eastfield, Timberhill, and Pine Ridge (one vacant position) o 1 Nurse Manager for the Infirmary o 1 Night Shift Supervisor • 32 RN Case Manager Positions (one vacant position and one frozen position) o 1 Unit RN Case Manager for the Infirmary o 4 Unit RN Case Managers for Houston Park o 6 Unit RN Case Managers for Cedar Falls o 3 Unit RN Case Managers for Timberhill o 3 Unit RN Case Managers for Pine Ridge o 4 Unit RN Case Managers for Eastfield	

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		o 5 Unit RN Case Managers for West Ridge o 4 Unit RN Case Managers for Garden Ridge • Nursing Supervisor Positions o 2 RN House Supervisors, one for each shift (night position vacant) o 1 RN Weekend Supervisor who works a double shift • 89.6 Staff RN Positions (approximately 16 positions were planned to be redistributed) o 16 Staff RNs for Cedar Falls and Houston Parks (eight on day shift and eight for evening shift o 21.5 RNs for West Ridge and Garden Ridge (13.5 for day shift and eight for evening shift) o 19.5 RNs for Eastfield, Timberhill, and Pine Ridge (10 for day shift and 9.5 evening shift) o 10 RNs for Infirmary (five for day shift and five for evening shift) o 6 RNs for night shift campus wide. • 77 Staff LVN Positions o 25 LVNs for Cedar Falls and Houston Park (13 for day shift and 12 for evening shift) o 15 LVNs for West Ridge and Garden Ridge (six day shift and nine for evening shift) o 21 LVNs for Eastfield, Timberhill, and Pine Ridge (nine for day shift and 12 for evening shift) o 7 LVNs for Infirmary (three day shift and four evening shift) o 10 LVNs for night shift campus wide • 6 Clinic LVN Positions o 4 LVNs for Unit Clinics o 1 LVN for the First Aid Clinic LVN o 1 LVN for the Neurology and Eye Clinic • Other Nursing Positions o 2 RN Hospital Liaison Nurses o 1 RN Infection Control Nurse o 1 RN Diabetic Nurse Educator, an additional position approved using existing full time Equivalent (FTE) o 1 RN Nurse Educator o 2 Quality Assurance Nurses (not supervised by the Nursing Department) o 1 RN Nurse Investigator (not supervised by the Nursing Department) The CNE stated to further improve nursing staffing patterns with existing staff that on 8/24/10 a proposed plan to fill vacant nursing positions had been submitted to the State Supportive Living Centers Assistant Commissioner and Nursing Coordinator requesting	

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		redistribution of the 53 RN II FTEs. The proposed recommendations included: Keeping 12 of the RN II positions for new graduates and lesser experienced nurses. Encourage RN II nurses to apply for RN III positions as they gain experience. As RN II nurses move into RN III positions, one half of the remaining 41 RN II positions would be converted into RN III positions and the other one half of the RN II positions would be converted into LVN III positions. Other recommendations included continuing to revise recruitment strategies as the market changes. One strategy was to hold a job fair on site for nurses with Career Builders. The goals of the proposal were to fill all vacant positions by the end of the calendar year and as new nurses were hired discontinuing filling those positions with agency nurses. It was commendable that the recently employed, (for approximately six weeks) CNE was forward thinking in analyzing existing nursing staffing patterns and developing a proposal for better utilization of existing nursing positions. The CNE needs to continuously evaluate nursing staffing demands because of an aging population compounded by many individuals who have co-morbid conditions. Therefore, individuals who reside at the Facility have the potential to require increased health care over time. <u>Training</u> Since the baseline visit the Nursing Department had provided competency-based training on State Policies as verified through training rosters: • Care Plan Development for RN Case Managers was provided by the RN Case Manager Supervisor and also provided during Nursing Skills Fair. • Comprehensive Nursing Assessment training was provided by the RN Case Manager Supervisor during the RN Case Manager Meetings. • Post Anesthesia Care training was provided in the Nursing Skills Fair. • Medical Emergency Response and training on the use of Automatic External Defibrillator (AED), and Emergency Competency Checklist was provided campus wide. Other training provided by qualified specialists to the nursing staff since the baseline review and validated through training roster included: • Fall Risk in Adults with Developmental Disabilities, 4/30/10, a Webinar presentation, sponsored by the Quality Monitoring Program, Texas Department of Aging and Disability Services, Center for Policy Innovation, and Quality Assurance and Improvement • Physical Nutritional Management Team (PNMT): Identification of Risk and Development of Interventions, presented by Karen Hardwick, PhD., OTR, FAOTA, July, 2010 While training rosters were made available for review to validate training, it was not possible to discern the percentages of nurses trained on any one single topic. The Nurse	

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		Educator needs to develop and implement a system for tracking all required training to ensure that 100% of the nurses receive the training and that training was completed within the specified time frame. <u>Quality Assurance/Peer to Peer Review</u> The Quality Assurance and Nursing Department adopted and Implemented the Settlement Agreement Monitoring Tools in June, 2010. While neither Department had formalized procedures for using the Tools, they each had a process in place for utilizing Tools. The Quality Assurance Nurse audited nursing-related Monitoring Tools as did the Nursing Department. In June, 2010, the Nursing Department assigned 21 Nursing Section Leaders to complete specific Tools in order to get familiar with their use. Then, starting on 7/1/10, the RN Case Manager Supervisor trained the RN Case Managers on the use of the 21 nursing Monitoring Tools. Thirty-two RN Case Managers began completing monthly audits on 32 individuals, randomly selected by the Quality Assurance Department. This represented a 5% monthly sample size of the total population. Because of the randomly selected samples, a peer to peer audit process was used. Upon completion of the audits the RN Case Managers turned in the audit reports to Nursing Administration. The Nursing Section Leaders analyzed the data. According to the CNE two areas of concern had been identified: documentation and response to illness and injury. The areas of concern were being given increased attention during nursing orientation and the Nursing Skills Fair. The CNE stated that the data were not yet reliable. Consequently, none of the audit data completed by the RN Case Managers were available for review. Audit data completed by the Quality Assurance Nurse also was unavailable. As the Nursing Department gains more experience with the use of Monitoring Tools, instructions need to be developed and implemented for each tool as well as for establishing inter-rater reliability at 85% or above. Development of such procedures needs to be done in collaboration with the State Office to ensure that all Facilities use the same audit criteria and documentation to evaluate outcomes consistently across the state. The quality of the audit data must be taken into consideration to achieve substantial compliance. Simply having checked that an item on the Monitoring Tool was present does not necessarily determine compliance. Critical thinking must be applied to the item audited to ensure that the documentation reviewed or observations made meet the clinical needs of the individual and are in accordance with the Settlement Agreement and Health Care Guidelines. The Nursing Department needs to develop a Nursing Peer Review Committee that reviews and analyzes audit data derived from the peer reviews in an effort to identify and solve problems in nursing practice as a means to improve the quality of nursing services provided. As the process matures, data generated should facilitate improvements in nursing practice and begin to move the Nursing Department	

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		toward compliance with the Settlement Agreement. The Nursing Department's current policy regarding Nursing Peer Review that addressed peer review from an investigative standpoint needs to be revised to reflect peer review from a quality improvement process, as defined by the American Nurses Association (ANA) in 1988. According to the ANA definition, "peer review is an organized effort whereby practicing professionals review the quality and appropriateness of services ordered or performed by their professional peers. Peer review in nursing is the process by which practicing Registered Nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers, as measured against professional standards of practice." <u>Documentation</u> According to the Chief Nurse Executive the Facility had been documenting in the SOAP (Subjective, Objective, Assessment/Analysis, and Plan) format since 1976 so the Settlement Agreement and Health Care Guidelines requirement was not new to the nurses at DSSLC. The nursing staff routinely receive training on documentation every the six months at the Skill Fairs. Documentation Trends: • The SOAP method of charting was used consistently in the Integrated Progress Notes reviewed. The overall quality of the content of the Integrated Progress Notes was more comprehensive than the notes reviewed during the baseline review. There were consistent assessments and documentation on individuals at risk for pain and/or behavioral changes. There were some trend issues of concern identified. • Identified health issues were not consistently carried forth in subsequent notes or there were no notes for issues referred to in subsequent note. • The "P" for plans of the SOAP notes consistently made a generic statement, e.g., "Carry out Physician Orders and nursing management" or"Continue current plan of care" or "Monitor and notify physician for any changes." This statement was too non-specific for other team members to know what physician orders, nursing management, and monitoring were to be completed. The Nursing Department needs to ensure that the "P" component of SOAP notes describes precisely what physician orders, nursing management, and monitoring will be carried out. • Documentation errors were not always corrected properly with a line drawn through the erroneous documentation, dated and initialed by the nurse committing the documentation error. • Blank lines were not consistently crossed out. • Documentation entries did not consistently include the time of the entry.	

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		• The method used to take temperatures was not documented. The Nursing Department needs to ensure that nurses document the method used for taking temperatures. • Nurses did not consistently document therapeutic response to antibiotic therapy. • Abbreviations were used that were not on the approved on the Facility's, e.g., LSCTA, or continued to use abbreviations that were no longer in use, e.g., SQRA for Standard of Quality and Risk Analysis. The Facility needs to review and update the Abbreviation List. • Records did not consistently include individuals' names and/or identification numbers. • The new record format did not enable the user to readily access nursing clinical data, because the Annual Comprehensive Nursing Assessment was filed in the Program Assessment part of the record while the Quarterly Comprehensive Nursing Assessment was filed in the Medical section, . Additionally, there were numerous different types of nursing documents contained under the nursing tab. Most did not have individual tabs; if they did, the tabs were so small they were difficult to read and quickly locate. The Facility needs to evaluate the functional order of the records to ensure continuity of nursing data and develop a user friendly tab system, using larger tabs for nursing data that can be easily read and found. <u>Acute Illness and Injury</u> <u>Records for individuals #409, #6, #32, #776, and 514 serve as examples regarding nursing staff's management of acute illnesses and injuries:</u> On 9/26/10 the physician diagnosed individual #36 with a urinary tract infection. Orders were given to treat with Levaquin 750m daily for seven days and to obtain an immediate (STAT) urine analysis via straight catheter. There were no Integrated Progress Notes indicating that the individual was catheterized and a urine specimen sent to the lab for a STAT urine analysis. There were no entries in the Integrated Progress Notes from 9/17/10 until individual #36 was seen by the physician on 9/26/10. The next entry in the Integrated Progress Notes was on 9/27/10 at 6:30 a.m. At that time the staff nurse completed a nursing assessment that included "*<u>S:</u> Dx Infection. <u>O:</u> In bed sleeping HOB is up. v/s 96%, 90/44, 71,16. Lung sounds are moist with rhonchi Bilat. ABD is firm and round. Last BM 9/26/10 MS. No s/s of pain/distress noted at this time. <u>A:</u> Infection. <u>P:</u> Con't Levaquin 750 mg daily. Report any Δ to physician."* The infection was not identified as urinary tract infection nor was there any documentation regarding the assessment relating to the status of the urinary tract infection or planned interventions such as an Acute Care Plan. There was no documentation that the direct care	

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		professionals were instructed in the care of individual #36's urinary tract infection. There was no Acute Care Plan made available for review. Further individual #36's lung sounds were identified as moist with rhonchi heard bilaterally. There was no documentation that the nurse notified the physician of the lung sounds. According to the physician's Integrated Progress Note on 9/27/10 at 8:30 a.m. the physician did check individual #36 and ordered a chest x-ray. The next note at 5:00 p.m. on 9/27/10, written by the RN Case Manager indicated the physician was called and an order received to hold the Macrobid (taken as prophylaxis to reduce incidents of urinary tract infection) until Levaquin was completed. The documentation of assessment and follow-up care for individual #36's urinary care was grossly inadequate. There should have been documentation regarding signs and symptoms of the impending urinary tract infection and notification to the physician at the first identification of signs and symptoms of urinary tract infection. The physician was obviously notified because individual #36 was seen, diagnosed and treated, but there should have been documentation to this fact. There should have been an Acute Care Plan established at the time the urinary tract infection was diagnosed and the direct care professionals trained in on their areas of responsibility. There were no further Integrated Progress Notes for review after 9/27/10. Therefore, how well individual #36 responded to care received was not possible to assess. There should have been documentation that the physician was notified of the moist rhonchi lung sounds. Again, the physician was obviously notified according to the physician's note on 9/27/10 at 8:30 a.m. If information related to assessment and care was not documented, there is no way to confirm was done. If compliance is to be achieved with regard to acute illness and injuries the Nursing Department needs to retrain nurses in managing acute illnesses and documenting actions, and must stringently monitor for compliance. Individual #32's Integrated Progress Notes on 9/16/10 at 8:10 p.m. reported that individual #32 began complaining of chest pain. The nurse assessed vital signs, temperature 97.7, pulse rate 90, respiration 20, O2Sat 96% on room air, and breath sounds were reported clear. The physician was notified and ordered Tylenol 650 mg to be given immediately and to continue to monitor. On 9/18/10 at 2100 individual #32 was reassessed and found to continue to complain of chest pain. Vital signs were temperature 98.1, pulse rate 102, respirations 16, and O2Sat 96% on room air, breath sounds present in all four quadrants. Respirations were report as deep and slightly labored. The physician was notified and ordered individual #32 transferred to the hospital. At 2133 Individual was transported to the hospital by Sacred Cross. The nurse completed and documented adequate assessments and promptly contacted the physician who after the second notification of chest pain gave the order to transport individual #32 to the hospital. It was of concern that the physician did not come to the home or send individual to the emergency room for evaluation when notified the first time based on	

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		medical history. Individual #32 was a 60 year old who had a stroke 5/8/10 and has a diagnosis of hypertension with chronic lymph edema of the lower extremities. Once individuals were admitted to the hospital the Hospital Liaison Nurse provided verbal report each morning to the medical staff, Case Manager Supervisor, and Infirmary nurses. When individuals were discharged from the hospital, individuals were triaged through the Infirmary. The Hospital Liaison Nurse's notes were scanned into the computer to be available to the RN Case Managers and Infirmary nurses. Hard copies of notes were filed in the Integrated Progress notes. This was an improvement from the baseline review when the Hospital Liaison's notes were only entered into the computer to share. This was validated through review of the Hospital Liaison Nurse's daily notes contained in the Integrated Progress Notes for individual #32's hospital admission for chest pain, 9/20/10 through 9/27/10. At the time the monitoring team's review ended on 10/1/10, individual # 32 remained in the hospital receiving a cardiac work-up. The monitoring team was concerned that the importance of response to emesis was not recognized. For example, records reviewed for individual #776 revealed the following findings: On 7/7/10 individual #776 was admitted to the Infirmary post hospitalization after having been diagnosed and treated for septicemia, leukocytosis, aspiration pneumonia, bilateral pleural effusion, sigmoid colitis, diverticulitis, atelectasis, hiatal hernia, mild right anterior abdominal wall hernia, positive for vancomycin-resistant enterococcus (VRE), and a healing abdominal wound from a previous surgical G and J-Tube insertion. On 7/8/10 at 8:10 a.m. the Nurse Practitioner's note stated, "Report of emesis (small amount – 20 + 200cc) during the early hrs of the a.m. Feeding held 2hrs". There was one note written by the nurse on 7/8/10 at 2:20 a.m. but this note did not include documentation regarding the emesis or withholding feeding for two hours that the Nurse Practitioner noted. Vomiting is a critical clinical indicator that must always be thoroughly described, e.g., time of the occurrence, number of times, amount, color odor and consistency, followed by a complete nursing assessment by a RN, and nursing actions taken, with all information documented and followed through to resolution. The complete nursing assessment and documentation was particularly critical for individual #776 because of high risk for aspiration and a history of multiple episode of aspiration pneumonia. Vomiting is never normal and should never be treated casually, particularly in individuals who are at high risk for aspiration pneumonia and and/or individuals enteral nourished. Vomiting always indicates an underlying problem that requires a thorough assessment of not only vital signs, including O2Sats, but must include a full respiratory and abdominal assessment. The physician should always be notified of each episode of vomiting. The Nursing Department needs to re-train all staff nurses in the Aspiration Pneumonia Clinical Protocol and vomiting Protocol. The Nurse Managers should monitor nurses for adherence to these two protocols.	

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		On 9/27/10 at 0130 the nurse documented in the Integrated Progress Notes that staff reported individual #514 was "throwing up". The nurse described individual #514 as awake but sleepy. A large amount of brown liquid was seen in bed. Individual #514 was responsive. Abdomen was soft, non tender; bowel sounds were present in all four quadrants. Lower bilateral extremities with 3+ pitting edema which the physician was notified (earlier in the day) . No signs of distress at that time. Temperature 96.6, pulse rate 68, respirations 18, blood pressure 96/48, and 95% O2Sat on room air. The nurse assessed individual as having an alteration in GI status. The nurse's plan was for staff to put individual #514 in recliner to minimize aspiration, if individual #514 "throws up" again. The nurse failed to complete an assessment of lung sounds, identify the origin of the "brown liquid" found in the bed, and notify the physician of the vomiting. The terminology the nurse used to describe vomiting, e.g., "throwing up", was non professional, even though that may have been the term used by the direct care professionals to describe vomiting. The nurse's handwriting was very difficult to read and the signature and title totally illegible. On 9/27/10 at 8:30 a.m. the nurse documented in the Integrated Progress Notes that staff had reported individual #514 had vomited at 6:28 a.m. Individual #514 was described as being in a recliner in the living room area with lower extremities elevated. In no respiratory distress at that time. Vital signs were reported as temperature 97.6, pulse rate 67, respirations 22, 96 – 97% O2Sat on room air, and blood pressure 122/97. Abdomen was reported firm to touch and bowel sounds were sluggish in all quadrants. Individual #514 was reported to have had a large bowel movement on 9/26/10 on the 2-10 shift. The nurse instructed the staff to put individual #514 in bed for her to assess for constipation. Upon assessment, hard pebble-like stool was found in the rectum. Dulcolax suppository was given with result pending. The nurse wrote, "As per 24 hr reported individual had vomited x 3 and was placed on CL to [be] seen by MD today." The nurse assessed individual #514 as having alteration in nutritional status. The plan was that she instructed the staff and nurse to report further emesis or change in status. Again, the nurse assessing individual #514 after the vomiting episode at 6:28 a.m. failed to assess lung sounds. On 9/27/10 at 0900 the nurse documented in the Integrated Progress Notes that she was called by the nurse who evaluated individual #514 earlier and reported that individual was short of breath. The nurse reported that individual #514 was noted to have mild wheezing on inspiration, grunting with respiration, pale, lethargic, and diaphoretic. Vital signs were reported as temperature 98.8, pulse rate 78, respirations 26 – 28, labored and uneven, with an O2Sat of 92%. The physician was called, informed of individual #514's condition, and received orders to transfer via Emergency Management Services (EMS).	

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		The 3333 protocol was initiated. Individual was place on 3 liters of oxygen. Individual #514 was transferred to the hospital via EMS at about 7:25 a.m. Individual #514 expired at the hospital later in the day. Again, due to the signs and symptoms of respiratory distress the nurse should have completed an assessment of individual #514's lungs and abdomen before calling the physician. Met with the CNE and NOO after reviewing the documentation and discussed the nursing care and documentation regarding individual #514. Monitoring team expressed concern over the failure of the night shift nurse to adequately assess individual #514's respiratory status after the first episodes of vomiting, identify the origin of the "brown liquid found in the bed, and notified the physician of the vomiting as well as the two other episodes of vomiting report on the 24 hr report. In addition, discussed the failure of the other two nurses who failed to assess lung sound after the episode of vomiting reported on 9/27/10 at 8:30 a.m. and 9:00 a.m. Also discussed individual's vital signs, particularly those taken on the night shift where the temperature was 96.6 and blood pressure 96/48 which may have been below baseline and could have indicated the onset of sepsis. The Facility has had several deaths due to sepsis. It is imperative anytime individuals vomit that nurses assess lung sounds to rule out potential for aspiration. Only assessing bowel sounds, vital signs, and O2Stats, while important to do, does not provide the nurse with adequate clinical indicators for which to identify whether individuals have aspirated. In response to the failure of the nursing staff to adequately assess and record episodes of vomiting and promptly notify the physician, the CNE took immediate corrective action. On 9/28/1 the CNE sent all nurses an e-mail directing them to: • Ensure providers (physicians) are contacted in a timely manner when indicated. • A nursing assessment should be performed on all residents with symptoms of acute illness. • Review and compare vital signs including O2 saturation to baseline for that individual. • Assess lung and bowel sounds following incidence of emesis. • The medical provider should be contacted immediately no matter the time of day or night if findings indicate. (When I doubt call) • Follow the SBARS Report to Physician when calling the provider to ensure complete and concise information is communicated. • Document all findings completely, accurately, and legibly. On 9/29/10 the CNE sent the Facility Director an e-mail outlining plans for corrective action related to assessment after vomiting episodes. Plans included: • The Nurse Educator will reinforce training on notifying physician, particularly	

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		with the night and agency nurses. • Nurse Educator will teach nurse the need to assess lung sounds after vomiting. • Nurse Education to teach nurses critical thinking skills. • Nurse Educator to teach comprehensive physical assessment skills The Nursing Department needs to ensure that nurses complete lung assessments after individuals vomit due to the high risk for aspiration pneumonia. The Nurse Educator needs to competency-base re-train nurses on the Aspiration Clinical Protocol and Vomiting Protocol. The Nurse Educator needs to train the nurses on the signs, symptoms and management of sepsis. The Facility's Medical and Nursing Departments need to re-evaluate their protocol as to when to notify the physicians regarding signs and symptoms of acute illnesses and injuries. The Nursing Department needs to reinforce the use of SBARS (situation, background, assessment, recommendations and, summary) Report to a Physician method of reporting to physicians. The monitoring team met with the Facility Director and other investigative staff and discussed concerns about the nursing care individual #514 received 24 hours prior to transfer to the hospital. The Facility reported individual #514's health care issues to the Department of Adult Protective Services for further investigation. Records were reviewed for individual #409 who was reported to have fallen in the bathroom striking his head on 9/18/10 at 810 p.m. A neuro check was initialed immediately and repeated in one hour, and then every four hours for 24 hours. All Neuro checks were negative. Neuro checks were documented on the Neurological Checklist and in the Integrated Progress Notes. It was a positive finding that the Neuro checks were completed according to protocol. It was graded "mild", the Neuro protocol called for an initial Neuro check, and then in one hour, then every four hours for 24 hours or until Neuros deemed stable. Review of individual #580's record's Integrated Progress Note on 7/17/10 had a late entry for 7/9/10 (time not indicated) that stated that staff reported t individual #580 complained of right wrist pain. The right wrist and hand were observed with no swelling found, the individual was able to move hand and fingers well, and radial pulse was present. Individual #580 was reported to show no signs or symptoms of pain nor did individual #580 complain of pain. The nurse's assessment stated no injury noted and no distress. The plan was to continue to monitor and for staff to report changes to nursing. The next entry in the Integrated Progress Notes was on 7/12/10 at 1615 where the nurse wrote that Individual #580 complained of right wrist pain. The nurse reported that the right wrist had 1+ edema and was hot to touch but had no redness or signs and symptoms of pain or discomfort. The nurse's assessment stated, "at risk for discomfort	

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		related to edema." The plan was to put on clinic list and to continue to monitor. The RN was notified. The individual was not seen in clinic the next day. It was not until 7/15/10 at 1100 that the RN Case Manager assessed individual #580 and found the right hand wrist and arm swollen up to the elbow. There was no redness or warmth noted, capillary refill less than three seconds, radial pulse palpable. A very light yellow bruise was noted at the wrist and medial surface. Individual #580 was not able to make a fist, arm strength was diminished. The nurse reported that the wrist pain was first reported on 7/10/10. This contradicted the previous late entry note on 7/9/10 that stated individual #580 complained of wrist pain. The RN Case Manager assessment stated, "Risk for impaired circulation related to swelling." The RN Case Manager immediately referred individual #580. On 7/15/10 at 11:15 the Nurse Practitioner assessed individual #580, ordered an x-ray done that day, and applied an ACE bandage to hand and wrist until x-ray results returned. On 7/15/10 at 1500 x-ray results indicated that individual #580 had a non displaced distal ulnar fracture of the right wrist. At 1515 Individual #580 was sent to the emergency room for fracture stabilization. Individual #580 returned home at 1915 after treatment in the emergency room with a soft arm cast wrapped with ACE bandage. It was of great concern that individual #580 first complained of right wrist pain on 7/9/10 but did not receive proper medical attention until 7/15/10. The nursing staff should have suspected the possibility of a fractured wrist related to the pain and swelling, stabilized the wrist, and immediately notified the physician. The nursing staff failed to exercise prudent practice in not recognizing the individual had an underlying problem with the swelling of the hand and wrist. Swelling of an extremity or any part of the body is not normal; there is always an underlying cause that must be evaluated at the first signs. After Individual #580's fractured wrist was diagnosed and treated, the follow up care documented in the record met professional standards of care. The Nursing Department needs to ensure that the nurses who failed to recognize and respond to the possible fractured wrist are retrained in physical assessments and monitored closely until full competency can be assured. The Nursing Department had recently adopted and implemented the Nursing Protocol for Post Anesthesia Care. Review of Pre/Active/Post Sedation Checklists for individuals: #715, #485, #517, #228, and #198 found that all were completed according to protocol.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as	Since the baseline review DSSLC had adopted and implemented Guidelines for Comprehensive Nursing Assessment and the accompanying Comprehensive Nursing Assessment Form. All RN Case Managers were trained in the use of the Comprehensive Guidelines by the end of July, 2010. RN Case Managers began using the Comprehensive Nursing Assessment Form in August, 2010. The monitoring team reviewed records for individuals #419, #206, #595, #387, #198,	N

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	indicated by the individual's health status.	#685, #638, #32, #776, #298, #276, #715, #36, #214, #342, #381, #616, #326, #596, and #496 with focus on their current Positive Support Plans, last six months' Quarterly Nursing Assessments, last six months' Health Maintenance Plans, and Acute Care Plans for compliance purposes. The Nursing Assessments of Annual and Quarterly Nursing Assessment as well as the Assessment Section of the Positive Support Plans (PSPs) for these 20 individuals showed progressive improvement since the baseline review. The most notable improvements were found in the assessments completed since August, 2010. All (100%) of nursing assessments were timely and in accordance with their PSP schedules. The assessments contained more substantive information in the Section Summaries and in the overall Nursing Summaries related to individuals' health status during the quarter, current status, status of response to health care plans, and any need for change. Although the monitoring team recognizes the improvements, there still remains room for improvement. Listed below are examples of concerns identified through review of the Annual and Quarterly Nursing Assessments: • Individual #36's Health Stated Risk Scores, 8/12/10, indicated high risk levels for cardiovascular, osteoporosis, urinary tract infections, aspiration, respiratory other than aspiration, medical concerns, and dental. The Quarterly Comprehensive Nursing Assessment, 9/1/10, Section X Nursing Problems/Diagnosis failed to include diagnoses for urinary tract infections, osteoporosis, aspiration, and dental nor were HMPs developed specifically for these diagnoses. Nursing problems/diagnoses were included relating to risk of respiratory infection and difficulties related to tracheostomy with ventilator dependence but did not specifically address aspiration. According to the Section XI Nursing Summary individual #36 was receiving Macrodantin 100 mg daily as prophylaxis for urinary tract infections. However, on 9/26/10 individual #36 was diagnosed and treated for a urinary tract infection. There was no Acute Care Plan (ACP) for the urinary tract infection available to review, although the monitoring team requested copies of all ACPs. Therefore, the effectiveness of the plan of care for urinary tract infection could not be evaluated. This demonstrated the need for a HMP for urinary tract infection. All high risk issues need to have HMPs designed to improve, maintain, and/or to recognize signs and symptoms when health conditions become unstable in order to quickly intervene and prevent progression of the problems. The Nursing Summary included a general summary of health status over the past quarter but failed to specifically relate the data to the effectiveness of the HMPs. The monitoring team reviewed HMPs for: Risk of skin impairment, alteration in neurological system related to seizure disorder, respiratory difficulties related to tracheostomy with ventilator dependence, alteration in nutrition related to	

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		enteral feedings, alteration in neurological function related to potential for tardive dyskinesia due to taking Reglan (The 180 Day Medication Orders did not include Reglan but the HMP for tardive dyskinesia may needed to have continued after the discontinuation of Regan to monitor for side effects for tardive dyskinesia.), risk for respiratory infection related to tracheostomy, alteration in elimination related to constipation, and self administration of medication prerequisite. The HMPs were somewhat individualized but the interventions failed to specify the frequency they were to be performed. The instructions for teaching direct care professionals regarding the HMPs were generally non-specific and failed to contain verification that direct care professionals had received training. • Individual #214's Health Status Risk Scores, indicated high risk levels for: GERD, osteoporosis, and constipation. Quarterly Comprehensive Nursing Assessment, 9/20/10, Section IX Nursing Problems/Diagnoses listed: Alteration in skin integrity, constipation, seizure disorder, GERD, and pain. The nursing diagnoses on the HMPs were not consistent with the nursing diagnoses listed in Section X. HMPs included Alteration of nutrition related to enteral feeding device, risk for impaired skin integrity, alteration in elimination related to constipation, alteration in neurosensory function related to seizure activity, impaired bone formations related to osteoporosis, potential for altered health maintenance related to: Gastrointestinal disturbance/GERD, anemia (mild), osteoarthritis of the right knee and left knee bursitis, and risk for infection, and impaired physical mobility related to mild spastic quadriplegia. The HMPs and nursing diagnoses need to be the same. The HMP for potential altered health maintenance related to: GI/Disturbance, GERD, anemia, and osteoarthritis of the right knee, and left bursitis were to nonspecific to be of value for any of the conditions listed; each condition needs a separate HMP. The nursing diagnoses and Health Maintenance Plans were developed prior to adopting the Health Care Protocols for Developmental Disability Nurse. The instructions for teaching direct care professionals regarding the HMPs were generally nonspecific and failed to contain verification that direct care professionals had received training. Section XI Nursing Summary failed to provide an adequate assessment of individual #214's health status related to each of the HMPs or their effectiveness. There was no comparison of health issues identified between quarters to assess if health status was improving maintaining or regressing. Individual #214 was receiving Reglan but the results of the MOSES and DISCUS were not included in the summary. There was no summary regarding seizure medication, e.g., Dilantin and Mysoline, blood levels, effectiveness of the	

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		medication or status of seizure disorder. Individual #214 had been receiving treatment for a chemical burn to the G-tube stoma but the assessment failed to summarize the treatment and status of wound healing. • Individual# 381's Quarterly Comprehensive Nursing Assessment, 8/3/10 was thorough in content and substance. Section X Nursing Problems/Diagnosis included all relevant active problems and diagnoses. Section XI gave a detailed summary of health status and effectiveness of identified nursing problems and/or diagnoses. Health Maintenance Plans were developed and individualized for each of the nursing diagnoses and/or problems. This assessment and accompanying care plans were outstanding and could be used an example for peers. Quarterly and Annual Nursing Assessments for the other individuals reviewed reflected progressive improvement, particularly when the newly revised Comprehensive Nursing Assessment Forms were used. As the RN Case Mangers gain experience with the use of the new form there should be continued improvement. The RN Case Managers need to continue to improve the quality of nursing assessments in the following areas: • Ensure that all active health/medical problems have Health Maintenance Plans, including those determined stable and/or may not be listed as high or medium risk. • Analyze the effectiveness of each HMP the Nursing Summary. If not effective, state what changes need to be made to the HMPs. • Ensure that Nursing Summaries include comparisons of health or behavior issues identified between quarters to assess if the individual's' health status was improving, maintaining, or regressing, and if there was progress or lack of progress in attaining measureable objectives, services, and/or supports that were included in the HMPs. • Ensure that individuals' therapeutic response to psychoactive and/or anticonvulsant medications are included in the Nursing Summary, particularly when new medications are prescribed and/or doses are adjusted up or down. Also include results of MOSES, DISCUS, and lab values. • Ensure that the status of each individual's Self Administration of Medication Program is included in the Nursing Summaries. • Ensure that that Annual and Quarterly Comprehensive Nursing Assessments are sent to the Qualified Mental Retardation Professional and other relevant PST members.	
M3	Commencing within six months of	The Nursing Department had adopted, implemented and trained the RN Case Managers	N

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	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.	in the Health Care Protocols for Developmental Disability Nurses in August, 2010, to use for developing HMPs and ACPs. Reviewed care plans for Individuals #419, #206, #595, #387, #198, #685, #638, #32, #776, #298, #276, #715, #36, #214, #342, #381, #616, #326, #596, and #496 showed significant improvement in the quality of the care plans developed since implementing the Health Care Protocols for Developmental Disability Nurses. However, not enough time had elapsed for all the HMPs to be converted to the new plans because the HMPs, unless there were new problems requiring HMPs, were developed and implemented at the time of the Annual Nursing Assessment. Most of the older versions reflected the same findings as were found in the baseline review because they were generic and lacked specificity related to the unique needs of individuals with intellectual and developmental disabilities. Acute Care Plans for the individuals reviewed were requested but few were included in the documents sent for review. By the time of time of the next tour there should be significant improvement in the HMPs. There were some overarching concerns that the RN Case Managers need to address. According to the Health Care Guidelines changes in psychoactive medications or those newly prescribed require an Acute Care Plan during the period of adjustment. The Facility's Nursing Department needs to ensure that when there is a change in the dose of psychoactive medications or when new such medications are prescribed that Acute Care Plans are developed, implemented, and the Home Leaders and direct care staff are trained in the plan. The Facility's Nursing Department needs to add a line for date on the HMPs and ACPs to validate that direct care professionals were trained. The Nursing Department needs to ensure that all care plans are individualized with realistic, achievable, goals that are measurable in order to evaluate if individuals are improving, maintaining or regressing..	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	The Nursing Department had adopted and implemented the State Office approved use of the Lippincott Manual of Nursing Practice 9th Edition for nursing procedures and protocols as well as the Healthcare Protocols: for Developmental Disability Nurses. The Nursing Department had also adopted and implemented the following State Policies: Care Plan Development, Guidelines for Comprehensive Nursing Assessment, Post Anesthesia Care, and Medical Emergency Response. The CNE participated with the Statewide Nursing Workgroup to develop Nursing Policies and Procedures to be used by all State Supported Living Center nursing staff. Policies, Procedures, and Guidelines in process by the workgroup included: • Acute Illness and Injury • Agency Nurse Orientation, Education and Training • Infection Control – Education and Monitoring/Auditing • Infection Control – Data Collection/Trend analysis/Infection Control Meetings	N

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		• Medical Restraint Nursing Protocol • Medication Administration Guidelines • Nursing Documentation Standards • Seizure Management • Physical Assessment and Documentation Seminar As these policies, procedures and guidelines are implement and have time to mature the overall nursing practices should show progressive improvement.	
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.	As evidenced by the Communicable Diseases by Select Code Reports, Clients Testing Positive for Tuberculosis (TB) Report, and Infection Control Committee Minutes, the Infection Control Department continues to track and analyze all infections including reportable communicable diseases, such as Methicillin-resistant Staphyloccus Aureus (MRSA) Hepatitis A, B, and C, Human Immunodeficiency Virus (HIV), positive tuberculin skin test, Hemagglutinin Type 1 and Neuraminidase Type 1 (H1N11), Clostridium Difficile (C-Diff), and Sexually Transmitted Diseases (STDs). The POI reported substantial compliance with action steps for showing that the Facility maintained a system for tracking data for infections and communicable disease as well as identifying outbreaks, and other problematic trends. The monitoring team concurs with the Facility's self assessment for these action steps and validated that through review of the Infection Control Department's Communicable Disease by Select Code Reports, Client Testing Positive for Tuberculosis (TB) Report, and Infection Control Committee Minutes. The POI reported substantial compliance with a system in place that ensures the reliability of these data. Monitoring team did not concur with this action step because the methodology for ensuring the reliability of the data was not provided for review. Infections were reported to the Infection Control Department in three ways: Twenty-four hour reports, Drug Utilization reports sent by the Pharmacy, and direct reports from nurses and other providers. The Infection Control Nurse Maintained and provided information sheets and infection-related acute care plans on the units. The Infection Control Nurse provided specific teaching and instruction to unit staff when needed. The Infection Control Nurse was involved with training during first quarter outbreaks, e.g., conjunctivitis in Cedar Falls, respiratory infections, and vomiting and diarrhea in Garden Ridge. In addition, the Infection Control Nurse facilitated a Webinar on Vaccine Preventable Diseases. Although such training was reported in the Infection Control Committee Minutes, there was no evidence provided the monitoring team to validate such training occurred. Review of the Infection Control Committee Reports for 1/1/10 through 3/31/10 (first quarter report) and 4/1/10 through 5/30/10 (second quarter report) revealed that the Committee continued to meet on a quarterly basis to review and analyze infection	N

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		control data: • The reports reflected that updated Antibiograms were distributed quarterly to each Infection Control Committee members with additional "pocket version" to physicians and nurse practitioners. The use of an Antibiogram was important to identify culture and sensitivity response to antibiotics used in the local community in an effort to prevent antimicrobial resistance among individuals treated with antibiotic therapy. The POI reported the action step for monitoring the use of antibiotics by the Infection Control Department and/or Pharmacy Department was in substantial compliance, as validated through Antibiotic Reports and Infection Control Minutes. The monitoring team concurs with the Facility's self-assessment for this action step. • There was evidence that the Infection Control Committee worked collaboratively with the Pneumonia Workgroup established 4/22/10. The Pneumonia Workgroup was established as a result of the high incidence of pneumonia identified and discussed during the baseline visit. Previous to the establishment of the Pneumonia Workgroup the Infection Control Department only tracked pneumonia infections that were treated at the Facility and did not include pneumonia infections acquired in hospitals and/or long term acute facilities. Thus, the infection control data did not reflect an accurate accounting of all cases of pneumonia infections. Consequently, the Infection Control Department had begun to include tracking pneumonia infections acquired in hospitals and long term acute care facilities. • At the baseline review the Infection Control Department did not have an instruction sheet for Impetigo; according to the second quarter minutes one had been developed. Another issue identified at the baseline review was the need for the Immunization Database to add projected due dates for immunizations requiring re-vaccination. According to the second quarter minutes this was added to the Immunization Database. This was validated through review of the Impetigo Fact Sheet and the Immunization Database. • Records reviewed for Individuals #419, #206, #595, #387, #198, #685, #638, #32, #776, #298, #276, #715, #36, #214, #342, #381, #616, #326, #596, and #496 indicated that all individuals were up to date with immunizations. • The Infection Control Committee Minutes reported monitoring results for staff compliance with proper hand washing. Results of compliance with proper hand washing for the first and second quarters are listed below by discipline: o First quarter monitoring results: ▪ Nursing met 100% compliance ▪ Direct Care Professionals met 97% compliance ▪ Physicians met 100% compliance ▪ Total compliance was 98% compliance	

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		o Second quarter monitoring results: ▪ Nursing met 93% compliance ▪ Direct Care Professionals met 88% compliance ▪ Physicians met 86% compliance ▪ Total compliance was 89% The reports indicated that the percentages were not accurate because they did not include Quality Assurance monitoring information. Monitoring and ensuring accurate hand washing data was important because one of the best ways to prevent the spread of infections is proper hand washing. The second quarter report expressed the concern that a number of MRSA colonized individuals and one VRE were currently on campus or in the hospital. The Health and Human Services and Centers for Communicable Disease (CDC) recommended that hospitals keep infected and/or colonized individuals in isolation until cultures were clear (three negative cultures). Due to the limited space in the Infirmary, the Medical Director was asked how to keep these organisms from spreading. The Medical Director advised continuing with observing Standard Precautions. Monitoring data for compliance with Standard Precautions and Environmental Surveillance was not included in the reports. It was reported that the RN Case Manager had begun using the shift overlap to conduct routine teaching on Standard Precautions. As reported above there had been 19 cases of MRSA reported since 4/1/10. This demonstrates the need for meticulous hand washing, use of Standard Precautions, and Environmental Surveillance to aid in preventing and/or reducing the incidents of infections. Documentation was requested for Infection Control training records but was not received in the document request. The Infection Control Nurse needs to ensure that staff are aggressively monitored for proper hand washing, use of Standards Precautions when indicated, and Environmental Surveillance monitoring. The POI reported substantial compliance with the action step for showing the Infection Control training curriculum and training rosters indicated that all staff were trained regarding hand washing practices according to CDC guideline. Evidence used to support this claim was that it was part of the new employee orientation. Training records validating that all new employees were trained in hand washing practices was not made available for review, as requested per document request. Therefore, this action step could not be evaluated for substantial compliance. The POI reported substantial compliance with the action step for showing the training curriculum and training rosters indicated that all staff were trained regarding Standard Precautions. Evidence used to support this claim was that it was part of the new employee orientation. Training records validating that all new employees were trained in Standard Precautions was not made available for review, as requested per document request. Therefore, this action step could not be evaluated for substantial compliance.	

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		At the time of the baseline review in April, 2010, the monitoring team expressed concern over the high incidence of aspiration pneumonia and other types of pneumonia identified during the tour, both Facility and hospital acquired pneumonia. Hospital physicians frequently failed to identify types of pneumonia. It was important to discriminate aspiration pneumonias from other types for preventative purposes. As a result of the concern the CNE stated that a Pneumonia Work Group would be established, comprised of an interdisciplinary team, to conduct a root cause analysis to determine underlying causes contributing to the high incidents of pneumonias. It was apparent through the review of the Pneumonia Work Group Minutes, 4/22/10, and 9/17/10, and Pneumonia Root Cause Analysis Report, 6/14/10, that the Facility had invested considerable effort into determine the underlying causes for the high incidence of pneumonia and to take corrective actions to minimize the incidents of all type of pneumonias. A detailed accounting of these efforts was included in this report to demonstrate such efforts. The Pneumonia Work Group convened on 4/22/10 and was comprised of an interdisciplinary team. The Work Group was charged to identify all possible risks for pneumonia and minimize those risks to the fullest extent possible. The Work Group reviewed and discussed 12 months of historical pneumonia data and identified eight homes reported to have had five or more incidents of pneumonia: 502C, 502D, 503B, 512A, 512C, 513A, 507C, and 552A. Action steps were developed to implement an initial effort to minimize the risk of pneumonia in the homes identified. Action steps included: • Conduct, at least, monthly meetings of the Work Group. • Add Dental Services and Respiratory Therapy to the Work Group. • Implement use of suction toothbrushes by May 3, 2010. • Ask Respiratory Therapist to wash nebulizers and masks after each use. • Explore the possibility of more frequent use of Pneumovax. • Have no “other” listed as type on pneumonia reports going forward. Get a definitive diagnosis for pneumonia. • Send a letter to the hospital asking them to indicate type of pneumonia, e.g., viral, bacterial or aspiration pneumonia. • Check into the need to refrigerate enteral formula. • Slow down mealtimes. Have budgeted time for medications and meals in the residents’ activity schedule. • “Clean up Our Act” campaign. • Clean air vents and perform environmental cultures. • Open windows and doors. • Monitor and share best practices. • Elevation on bathing tables.	

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		• Turn off feedings for15 minutes before moving individuals. Of the numerous action steps indentified by the Work Group it was decided that implementing the use of suction tooth brushes should be the first step to minimize aspiration pneumonia. The Work Group indentified 36 individuals in seven apartments for a 90-day suction tooth brushing trial. The Nurse Educator developed a teaching module for direct care professional staff on proper techniques of using the suction toothbrush. She educated the RN Case Managers who, in turn, in-serviced the direct care professionals working in the identified homes. The Nurse Managers and Unit Directors worked together to decide which individuals would have suction tooth brushing performed by the nursing staff and which by the direct care professionals. The Nurse Educator developed a checklist for individuals who needed suction tooth brushing, kept in-home shift logs checked off by the staff performing the tooth brushing. The nurses assigned to individuals were responsible for ensuring that suction tooth brushing was completed three times a day, every day. The Nurse Managers were responsible for obtaining the suction tooth brushing equipment. Other action steps taken included: • A house-wide emphasis on positioning: o Re-training of staff o Requested CSO rounds to observe for positioning and correct as needed • Implementation of the Aspiration Prevention Protocol • Increased the use of bolus enteral feedings • Requirement to evaluate swallowing mechanism post-hospitalization for individuals who experienced long-term hospital stays and who were at risk for aspiration • One hundred percent use of pneumonia vaccine for individuals who meet CDC criteria • Began weekly analysis of pneumonia days of all individuals hospitalized • Began weekly analysis of incidences of aspiration and non-aspiration pneumonia • Air vents in two homes were cultured; both were negative. The Pneumonia Root Cause Analysis Report, 6/14/10, identified the primary causes of pneumonia, in rank order, at DSSLC as: • Aspiration due to: o Posture/positioning, particularly due to individuals sliding down in bed from proper position to an improper position o Dysphagia, particularly new onset o Emesis o Resources were not always available to continually reposition individuals o Oral care – limited use of suction toothbrushes	

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		• Hospital acquired due to: o Improper positioning o Intolerance to enteral feedings o Dysphagia o Limited understanding of hospital personnel on the unique needs of this population Recommendations made as a result of the Root Cause Analysis included: • *Finish the 90-day suction toothbrush pilot and analyze outcomes for those eight homes. The pilot ends 8/1/10. Did it work? If so, continue and consider rolling out house-wide.* • *Take every precaution to prevent small-volume aspiration, including:* o *Evaluate use of recliners for individuals with enteral feedings to assess if proper posture can be maintained?* o *Re-train all staff who assist in feeding individuals or who supervise meals for posture, bite size, diet texture, swallowing mechanism, coughing, choking, and other important components of mealtime supervision.* o *Analyze gastric content residuals on individuals at risk for aspiration.* o *Increase staffing in the homes where individuals are at high risk of aspiration.* • *Evaluate GERD prevention across the campus.* • *Provide a rest period prior to mealtimes for those individuals at risk for aspiration.* • *Build a sufficient amount of time into the individual's daily plan to allow for a slowly paced meal. Do not rush meals.* • *Evaluate positioning (head of bed elevation) for all individuals who are non-ambulatory. Is 30 to 45 degrees sufficient?* • *Assess for abdominal cramping for those receiving enteral feedings. Stop feeding and refer to physician immediately if observed.* • *Increase residual checks to every four hours for those at risk for aspiration.* • *Increase oral care for all residents. Supervise the use of tooth brushing.* • *Cross-walk the Health Care Guidelines and Settlement Agreement against current actions taken to produce a gap analysis.* The Pneumonia Committee Meeting Minutes for 9/17/10 included a review and discussion of tracking data for aspiration pneumonia for June, 2010, through August, 2010. Twenty-four cases of aspiration pneumonia occurred during the reporting period. Seven of the 24 (29%) cases were in ambulatory individuals. Eight of 24 (33%) cases were receiving enteral feedings. Not all of the precursors were known. At least one individual was given the incorrect diet texture and/or liquid consistency by the hospital personnel. Two individuals prescribed thickened liquids took thin liquids and drank them. One individual had a head injury with resulting lethargy and swallowing problems. Other discussions and dispensations included: The Facility Director's meeting	

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		with the hospital administration (Denton Regional Medical Center). Prior to the meeting, the hospital's CNE requested and was sent a list of DSSLC's Cover Sheet that listed all the documents sent to the hospital when an individual was admitted to the hospital. A concern was expressed that the Facility may not be consistently referring individuals for gastric emptying studies when indicated. The Medical Director was to address this issue with the physicians. The Committee requested data regarding residual checks. The Nurse Educator was to review the process for residual checks and provide training as needed. The Infection Control Nurse was working on data related to hospital diagnoses issues and records availability. The Committee discussed the need for improved positioning during checking and changing individuals, bathing and use of mechanical lifts. The PNMT Coordinators were to remind direct care professionals regarding positioning issues. The Nurse Educator was creating a "Memory Jogger" poster for all staff. The suction toothbrush trial was continuing with the 36 individuals in seven apartments. Several problems were reported regarding equipment issues, protocol issues, and consistency. The Committee agreed to reduce the requirements for tooth brushing from three times a day to twice a day. It was suggested that some of the suction tooth brushing could be done while the individual attends Life Skills. The Nurse Educator and CNE were to address this with the Life Skills Director. The Pneumonia Work Group needs to include evaluating the correlation of the incidents of aspiration pneumonia with the precursors of vomiting episodes prior to developing aspiration pneumonia. Vomiting is never normal, rather a serious clinical indicator of an underlying medical problem that requires further assessment, diagnosis, and treatment. A tracking system for vomiting needs to be developed and implemented. The Nurse Managers or designees and PNMP needs to monitor vomiting tracking data to ensure that vomiting is addressed promptly. The Nurse Educator in collaboration with the PNMT needs to develop and implement a training module for vomiting, to include potential causes of vomiting, risk of aspiration pneumonia secondary to vomiting, how to describe, respond, report, and document. This training needs to be mandatory for all staff having direct responsibility for individuals' care. It was commendable that the Facility self initiated the Pneumonia Work Group to address the high incidents of all types of pneumonia. After review of the above information it was evident that many action steps had been put in place to minimize the incidents of pneumonias. The actions steps were multifaceted and may take some time to fully implement and refine before significant outcomes can be measured. At the time of the review such data were not available to demonstrate a significant reduction in the incidents of aspiration or other types of pneumonias. This issue will be reviewed again	

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		at the next tour to assess the progress of the Pneumonia Work Groups efforts to minimize the incidents of pneumonias. Review of the Pneumonia Tracking Report, 1/1/10 through 8/29/10, indicated: • There were 122 cases of all types of pneumonia of which 52 cases or 43% were for aspiration pneumonia and 70 cases or 57% were due to non- aspiration (viral, bacteria or not specified as to cause). • The 52 cases of aspiration pneumonia involved 43 individuals of whom 3 individuals (#776, #499, and #342) had three episodes of aspiration pneumonia and four individuals (#329, #466, #326, and #309) had two episodes of aspiration pneumonia. Sample of individuals' records reviewed revealed the following findings: o Individual #776 had multiple episodes of aspiration and non-aspiration pneumonias. A discrepancy was identified in the reporting of individual #776's pneumonia episodes between what was reported on the Pneumonia Tracking Report and what was documented in the record. According to the Pneumonia Tracking Report individual #776 had aspiration pneumonias reported on 1/31/10, 4/7/10, and 8/4/10 and non-aspiration pneumonias on 2/25/10 and 6/5/10. Medical Records indicated that individual #776 also had aspiration pneumonia on 1/22/10, 3/4/10, and 6/25/10 and non-aspiration pneumonia on 5/28/10. It is extremely important that pneumonia tracking data are accurate to use as clinical indicators for trending and managing individuals' health care. The professional staff responsible for reporting and entering pneumonia data into the Pneumonia Tracking system need to ensure that all diagnosed cases, by type, of pneumonia are accurately reported. • Of the 122 cases of pneumonia, 59 or 48% were enterally nourished and 63 or 52% were orally nourished. Of the 43 the individuals diagnosed with aspiration pneumonia, 27 or 63% were enterally nourished and 16 or 37% were orally nourished. It was a concern but not surprising to find when analyzing the Facility's pneumonia tracking data that the highest percentage of aspiration pneumonia occurred in individuals who received enteral nourishment. This demonstrates the importance for the Pneumonia Work Group to analyze pneumonia data related to the method of administration of nourishment or medication. A comparison should be made between those who were diagnosed with aspiration pneumonia verses the entire pneumonia data that includes all types of pneumonias. This should provide a more accurate picture as to whether individuals receiving enteral routes of administration of nourishment and medication were more or less at risk for aspiration pneumonia than individuals receiving oral intake. Analyzing data from this perspective should provide	

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		valuable information to use in planning interventions in order to minimize the incidents of aspiration pneumonia. • Of the 43 individuals with one or more episodes of aspiration, 14 or 33% had a high Health Risk Score for aspiration, while the remaining 29 or 67% did not have a high risk score for aspiration listed on the Health Risk Report, printed 9/6/10. Individuals who have had aspiration pneumonia are at great risk for repeated episodes. Therefore, the PSP, HST, and/or PNMT should meet immediately after individuals are diagnosed to review precursors that might have lead to the aspiration pneumonia. The PSP, HST, and/or PNMT should re-evaluate individuals' Health Risk for aspiration and the effectiveness of their plans of care to prevent future episodes of aspiration pneumonia. Review of 16 deaths reported from 1/6/10 through 8/4/10 indicated the following: • The first, second, and third causes of death were completed for 15 of 16 deaths; one cause of death was pending. • Of the 15 deaths with causes of death identified, seven or 47% were reported on the first and/or second cause of death as some type of pneumonia: o Aspiration pneumonia was reported as first or second cause for three of the deaths. o Other types of pneumonia were reported as first or second cause for four of the deaths. • Of the 15 deaths with causes of death identified, four or 27% were reported on the first, second, and third cause of death as sepsis. Vomiting with nausea was list as a third cause of death for one of the sepsis deaths. • Of the 15 deaths with the causes of death identified, one or 7% was reported as first cause of death as fungemia. There were no second or third causes of deaths listed. • Of the15 deaths with causes identified, one or 7% had first cause of death reported as uremia, second cause reported as end stage renal disease, and third cause of death reported as polycystic kidney disease. • Of the 15 deaths with causes identified, only two or 13 % had cardiac related (sudden cardiac death and congestive heart failure)causes of death reported as the first cause of death with the second cause of one death reported as atherosclerotic coronary artery disease. None of the second or third cause of death related to infectious disease processes. A cursory analysis of reported causes of death suggests that of the 15 deaths, 13 or 87% of deaths, when correlated with all causes of death (first, second and/or third) were associated with some form of infectious process, e.g., 47% related to some type of pneumonia with 27% related to sepsis. The results of this cursory analysis	

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		demonstrated a trend that most deaths were related to some form of infectious disease process. Therefore, the Infection Control Nurse, Quality Assurance Nurse, Nurse Educator, Medical Director, and other related interdisciplinary teams need to analyze and trend death reported data for causative factors contributing to deaths in an effort to develop and implement effective strategies to reduce the incidents of infectious diseases that may be causative factors contributing to the high incidents of deaths at the Facility. The Communicable Diseases by Select Code Reports for reportable infections for the reporting period since the baseline review, 4/1/01 through 8/31/10, were reviewed. The tracking data captured date of diagnoses, antibiotic therapy received, date of resolution, and Infection Control Department notes. The report included the type and number of reportable communicable diseases: Records reviewed for individual #776 and individual #32 demonstrated follow-up management of communicable diseases: • Individual #776 returned from a hospitalization on 7/7/10 diagnosed positive for VRE. There was documented evidence in the Integrated Progress Notes that staff were trained in contact isolation precautions related to VRE and followed through until the VRE was determined negative after three negative stools on 7/13/10. Individual #776 was diagnosed with C-Diff on 7/12/10 and treated with Flagyl 500 mg three times a day for 10 days. On 7/27/10 the first stool specimen for C-Diff tested positive. The decision was made by the Nurse Practitioner to discharge individual #776 from the Infirmary back to home in Houston Park even though individual #776's first stool specimen tested positive for C-Diff. The Nurse Practitioner stated that individual #776 was asymptomatic and with contact isolation precaution it would be safe to transfer home. There was documented evidence in the Integrated Progress Notes that the RN Case Manager provided training to home staff regarding contact isolation precautions related to C-Diff. The second stool specimen for C-Diff was negative on 7/28/10. Individual #776 was readmitted to the hospital on 8/4/10 for aspiration pneumonia. • Individual # 32 was diagnosed with MRSA of the nares on 5/18/10. Individual #32 was treated with Bactroban twice a day for seven days. An Acute Care Plan was initiated and isolation precautions were put in place. He was treated in the Infirmary until the MSRA was resolved on 5/25/10. The Acute Care Plan did not include verification that the direct care professionals were trained in the plan nor was the date of resolution documented on the plan. Skin Integrity Committee Minutes, 9/8/10, (only one report was made available for review) and Tracking Decubitus Report for Resolved and Unresolved Decubitus, 6/1/10 through 9/8/10, revealed the following findings. • Number of pressure ulcers reported for the last four quarters:	

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		o First quarter reported 21 pressure ulcers. o Second quarter reported 17 pressure ulcers. o Third quarter reported 23 pressure ulcers. o Fourth quarter reported 10 pressure ulcers. • At the time of the review there were four unresolved pressure ulcers: Individual #595 had two stage four pressure ulcers of the right and left popitial fossa (back bend of knees),Individual #206 had one stage two pressure ulcer of the left ischial tuberosity, and individual #519 one stage three pressure ulcer of left great toe. There was no Skin Integrity trend analysis of data completed to identify contributing factors causing pressure ulcers and preventative measures to prevent or reduce the incidents of pressure ulcers that could be used by applicable integrated team members to make clinical decisions. The Skin Integrity Committee needs to trend and analyze data to identify contributing factors causing pressure ulcers and preventative measures to prevent or reduce the incidents of pressure ulcers that could be used by applicable integrated team members to make clinical decisions. As was identified at the baseline review, the Skin Integrity Nurse continues to assess and stage pressure ulcers as well as direct wound care for individuals referred by unit nurses, clinic nurses, Nurse Practitioner, and physicians. The Skin Integrity Nurses follow up on referrals for pressure ulcers and/or wounds at least weekly or as indicated. The Skin Integrity Nurse works with nurses during the Nursing Skills Fair to provide education on assessment, staging pressure ulcers, and treatment modalities used in would care management. The units' primary care nurse assessed pressure ulcers and/or wounds daily or at the time of treatment in accordance with physician orders. Findings from records and discussion with the Skin Integrity Nurse for individuals' #595 and #206 with active pressure ulcers and/or wound included: • Individual #595 developed bilateral popitial fossa pressure ulcers in May 2010 secondary to severe contractures and wearing support hose. Review of individual #595's Integrated Progress Notes indicated that the pressure ulcers were being treated aggressively. Individual #595 was seen in the North Texas Hospital Wound Clinic every two weeks. In addition to routine wound care, individual #595 received a high protein diet to promote healing. The nursing staff assessed and provided treatment daily on every shift. The nursing staff described appearance but rarely indicated the size of the pressure ulcers. The Skin Integrity Nurse assessed the pressure ulcers at least weekly and more often when indicated. The Skin Integrity Nurse reviewed individual #595's record with the monitoring team. She described the course of treatment and	

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		therapeutic response, along with photographs taken over time that showed progressive healing. At the time of the review both pressure ulcers were almost resolved. • Individual #206's was treated for a stage II pressure ulcer of the left ischial tuberosity, 8/25/10 through 9/30/10. Individual #206 was identified on 8/25/10 at 2100 with an open area on the left buttock and was put on the clinic list to be seen the next morning. Individual #206 was assessed in clinic the next morning (8/26/10) by the physician and treatment was prescribed for the open area on the left ischial tuberosity. On 8/6/10 individual #206 was assessed by the Skin Integrity Nurses who assessed the pressure ulcer on the left ischial tuberosity as superficial stage II. Staff were instructed to report drainage on dressing to the nursing staff. There was documented evidence in the Integrated Progress Notes that the nurses carried out wound assessments and prescribed treatment daily on every shift. However, nurses failed to consistently describe the size and appearance of the wound. The Skin Integrity Nurse made at least weekly assessments and evaluated the size and status of wound healing. There was documented evidence that the Skin Integrity Nurse collaborated with the Dietitian and Occupational Therapist. On 9/9/10 the Occupational Therapist completed a pressure mapping of individual#206's wheelchair. The results of the pressure mapping showed no peak pressure areas when individual #206 was properly positioned in the wheelchair. The Occupational Therapist's plan was to encourage staff to ensure individual #206 was properly positioned in the wheelchair. The Occupational Therapist's plan stated that the Physical and Nutritional Management Coordinators (PNMCs) would monitor for the next few day. There was only one Integrated Progress Note written on 9/16/10 by a nurse stating that the Wheelchair Monitors evaluated individual #206's wheelchair for correct sizing and build. There was no documentation in the Integrated Progress Notes written by the PNMCs' indicating that they had monitored individual #206. On 9/13/10 the Dietitian prescribed Juven twice a day, a dietary supplement to promote healing. Review of Integrated Progress Notes and discussion with the Skin Integrity Nurse indicated that individual #206's left ischial tuberosity was almost healed by 9/30/10. The Skin Integrity Nurse showed photographs made at each assessment that demonstrated the progression of wound healing. While it was apparent that individual #206's pressure ulcer was healing, it was of concern that there was no acute care plan available for review for the newly diagnosed pressure ulcer or documentation in the Integrated Progress notes of specific training to the direct care professions. However, individual #206 did have a Health Maintenance Plan (HMP) for Risk of Impaired Skin Integrity, due to the history of pressure ulcers to	

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		the left hip, dated 12/14/09. The care plan was generic and did not address individual #206's unique need for skin integrity care, particularly as related to positioning and other means to reduce pressure on the ischial tuberosity. The HMP should have been reviewed and revised as individual #206's skin integrity status changed. Another concern identified was the fact that nurses failed to describe the size and appearance of the pressure ulcer when administering treatments and changing the dressings. There was no documentation in the Integrated Progress Notes indicating whether or not the direct care professionals were actually instructed by either the Occupational Therapist or nursing staff on how to properly position individual #206 in the wheelchair. Individual #206's pressure ulcer was first identified on 8/25/10. The Skin Integrity Nurse responded the next day, but it was 14 days later that the Occupational Therapist assessed the wheelchair positioning, and 18 days later before the Dietitian assessed nutritional needs and prescribed Juven to promote healing. It was imperative that when pressure ulcers were identified that the Occupational Therapist, Dietitian, and any other relevant disciplines respond quickly to assess and intervene to prevent further skin breakdown and begin the healing process. The Skin Integrity Nurse and Occupational Therapist need to ensure that acute care plans are developed for individuals with pressure ulcers. The acute care plans should meet individuals' unique needs to promote healing and further prevent pressure ulcers as well ensure that direct care staff are adequately trained. The Skin Integrity Nurse needs to continue to train nurses on how to assess and document the size, appearance, and status of healing of pressure ulcers. The Occupational Therapist needs to ensure when PNMCs are instructed to monitor individuals that they followed through and document their actions in the Integrated Progress Notes. When the Occupational Therapist and/or Dietitian receive a referral from the Skin Integrity Nurse to assess individuals with pressure ulcers they should respond timely. Reviewed the PICA Audit Tool for the week ending 9/24/10 on individuals #443, #285, and #107. Nurse Managers or RN Case Managers completed weekly audits on 5% of the records or five records, whichever was greater in each home, of the total known individuals with PICA tendencies. The audit results were submitted to the CNE and Standard of Quality and Risk Assessment (SQRA) the first week of every month. The unit nurses were required to conduct daily abdominal assessments on individuals with known PICA tendencies to identify any evidence on PICA ingestion. The CNE stated there were no formal written procedures for the PICA Audit but the directions for completing the Tool were written on the audit form. The PICA Audit Tool indicated there were no abnormal findings. There was no trend data analysis included for review. The monitoring team reviewed the supporting documentation in the records used for the audit results on individuals #443 and #107. There was documented evidence in the records that nurses conducted daily abdominal assessment on these individuals for	

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		which no abnormal findings were found. On 9/20/10 at 4:00 p.m. individual #443's Integrated Progress Note, for the "O" section of the SOAP note stated, "In w/c, ABD soft non distended, BS (bowel sounds) x4…" This lead the monitoring team to believe that the abdominal assessment was completed with individual #443 in the wheelchair. It was of concern that the abdominal assessment was completed with the individual #443 in a wheelchair. In order to complete an accurate abdominal assessment the individual needs to be in a reclining position. The Nursing Department needs to ensure that abdominal assessments are completed correctly with the individuals in a reclining position so that the abdomen can be adequately ascultated and palpated. Reviewed records for individuals: #419, #206, #595, #387, #198, #685, #638, #32, #776, #298, #276, #715, #36, #214, #342, #381, #616, #326, #596, and #496 demonstrated that all individuals had a Braden Skin Risk Assessment completed at each Quarterly and Annual Nursing Assessment.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The DSSLC Plan of Improvement (POI) reported lack of compliance with this provision. The monitoring team concurs. DSSLC POI reported they were in substantial compliance with some of the Provision's Action Steps: DSSLC indicated that records reviewed showed that there was a nursing procedure for administering medications in accordance with current, generally accepted professional standards of care. Evidence used to support their claim for substantial compliance included having in place a policy and procedure for medication administration. While the Nursing Department had a Medication Administration Policy, reviewed/revision Date: February, 2010, the policy only contained the basic fundamentals for medication administration. The policy failed to explicitly include all required medication administration practices relating to the role of the medication nurse in medication management, as required by the Health Care Guidelines and included in the Settlement Agreement Monitoring Tools as accepted medication practices. In addition, a major concern with the policy was it allowed the medication nurses to provide privacy by positioning their body or medicine cart in a fashion that blocked the view. This practice of providing privacy was neither acceptable nor possible when administering medications in open areas of the living units. Therefore, the monitoring team did not agree that this Action Step was in substantial compliance. The State Office had not yet revised the Medication Administration Policy and Procedures. When the State Office revises this Policy, it is integrated into the DSSLC Nursing Manual, and nursing staff are trained, further improvement should be evident as the Nursing Department continues to progress toward compliance with this provision of the Settlement Agreement and Health Care Guidelines.	N

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		DSSLC indicated that records reviewed showed that nurses were regularly supervised when administering medication to minimize medication errors. The evidence the Facility used to support their claim for substantial compliance was the change from monitoring medication nurses during Medication Administration Observations from annually to quarterly. Medication Administration Observations were completed by the Quality Assurance (QA) Nurse and Nurse Educator. This demonstrated progress from the baseline review where medication nurses were observed annually. The monitoring team verified that medication nurses were observed quarterly during medication administration through review of Medication Administration Observation Sheets, March, 2010, April, 2010, May, 2010, and July 2010 (Facility failed to include Medication Administration Observation Sheets for June, 2010). Observations were completed by the QA Nurse on nurses administering medicine in residential units. The QA Nurse used a Medication Administration Observation Form modified from audit criteria adapted from the Settlement Agreement Monitoring Tools for Medication Administration and Infection Control. Monitoring Medication Administration through use of this Tool began in March, 2010, and has continued to undergo refinement as relevant medication administration issues were identified that required improvement. Each item on the Medication Administration Observation Sheet was measured by percentage of compliance. All items were weighted equally. Each residential unit's Medication Administration Observation Sheets were summarized monthly, then, summarized for the entire Facility. The monthly Facility summarized Medication Administration Observation Sheets indicated the number of eligible candidates for quarterly observations, and then stated the actual number of observations completed for the month out of the eligible candidates. The QA Nurse documented deficiencies on the monitoring tool and plan for corrective action. Results of the Medication Observation Monitoring Tools and spreadsheets were sent to the Unit Nurse Managers as well as Nursing Administration. The QA Nurse made on the spot corrective action when deficiencies were found during medication administration. Medication nurses who failed to successfully administer medications or who required more than on the spot prompting were retrained by the Nurse Educator. Monthly findings from the Medication Administration Observations revealed the Facility's overall percentages and audit items failing to meet at least 95% compliance included: <u>March, 2010:</u> • A total of 40 medication pass observations were completed on nurses out of 68 nurses eligible for quarterly reviews, resulting in a review rate of 59% of the eligible nurses. • Overall Facility compliance for all items contained on the Medication Administration Observation audit tool was 97%.	

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		• Audit items failing to meet at least 95% compliance included: o Nurses initialed all medications given and/or circled medications not given prior to administering medications to the next person. Met 94% compliance. o Nurses followed current infection control precautions throughout the medication pass, i.e., cleaning hands between individuals, throwing trash into covered trashcan without contaminating hands, and keeping medication cart surface clean. Met 90% compliance. o Sharps containers were on or inside the medication cart. Met 69% compliance. <u>April, 2010:</u> • A total of 43 medication pass observations were completed on nurses out of 50 nurses eligible for quarterly reviews, resulting in a review rate of 92% of the eligible nurses. • Overall Facility compliance for all items contained on the Medication Administration Observation audit tool was 95%. • Audit items failing to meet at least 95% compliance included: o Nurses failed to check tube placement for bumper placement on individuals receiving medication via gastrostomy tube. Met 89% compliance. o When medications were refused or not given for some reason, nurses documented reason for omissions, including the nurse signature and title, on the back of the MARs. Met 75% compliance. o Nurses followed current infection control precautions throughout the medication pass, i.e., cleaning hands between individuals, throwing trash into covered trashcan without contaminating hands, and keeping medication cart surface clean. Met 88% compliance. o Sharps containers were on or inside the medication cart. Met 74% compliance. o Nurses followed the individuals' Self-Administration of Medication Plans, i.e., objectives, policy, data card, and certification of completion. Met 82% compliance. <u>May, 2010</u> • A total of 37 medication pass observations were completed on nurses out of 43 nurses eligible for quarterly reviews, resulting in a review rate of 86% of the eligible nurses. Fourteen nurses were deferred from observations until September because they attained 100% compliance on their last medication pass observations. • Overall Facility compliance for all items contained on the Medication Administration Observation audit tool was 96%. • Audit items failing to meet at least 95% compliance included:	

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		o Sharps containers were on or inside the medication cart. Met 58% compliance. June, 2010 data were not available for review. July, 2010: • A total of 14 medication pass observations were completed on nurses out of 14 eligible for quarterly reviews, resulting in a review rate of 100% of the eligible nurses. Thirty-one nurse observations were deferred to October because they attained 100% compliance on their last medication pass observations. • Overall Facility compliance for all items contained on the Medication Administration Observation audit tool was 96%. • Audit items failing to meet at least 95% compliance included: o Nurses provided individuals privacy during medication administration. Met 94% compliance. o Nurses checked the medication label against the MAR three times before administering medications to the individuals. Met 94% compliance o Nurses initialed all medications given and/or circled medications not given prior to administering medications to the next person. Met 94% compliance. o Nurses followed current infection control precautions throughout the medication pass, i.e., cleaning hands between individuals, throwing trash into covered trashcan without contaminating hands, and keeping medication cart surface clean. Met 89% compliance. o Sharps containers were on or inside the medication cart. Met 89% compliance. There was evidence from review of the above Medication Administration Observations Sheets that corrective actions were taken when the medication nurses failed to comply with items on the audit tool through immediate prompting or retraining. There were no written operational procedures or interpretative guidelines for performing the Medication Observations although there was a predetermined number of medication nurses observed monthly which resulted in observing most medication nurses on a quarterly bases. According to the information reviewed medication nurses who meet 100% compliance in one quarter were deferred from the quarterly reviews or delayed until some later date. The Settlement Agreement and Health Care Guidelines require quarterly reviews for each nurse administering medications. Unless such a requirement is changed, the expectation for compliance will remain for quarterly reviews. Although significant progress had been made regarding Medication Administration	

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		Observations since the baseline review, there remains more work to be done in refining the system before substantial compliance with this Action Step can be considered. As the Medication Administration Observation monitoring system develops the QA Department in collaboration with the Nursing Department needs to develop and implement operational procedures or interpretative guidelines to ensure consistency among the auditors as well as an inter-rater reliability procedure to ensure that reliable data are produced. A system needs to be established for tracking, trending, and analyzing data over time to ensure substantial compliance. Further, the system needs to include tracking to ensure that each nurse was observed at least quarterly. Medication Administration Observations were made for individuals in Houston Park, 515A and Timberhill, 508, on 9/30/10. The CNE and NOO accompanied monitoring team during the Medication Administration Observations. Observations revealed the flowing findings: • The medication nurse administering medications to individual #107 via G- Tube in Houston Park 515A followed correct medication administration procedures except for: o Failure to inform the individual #107 what she was doing, what medications she was administering, and their purpose. When prompted, the nurse did tell the team member the names and purposes of the medication she was administering. o Failure to implement individual #107's Self-Administration of Medication Plan. o Failure to provide adequate privacy during medication administration. Privacy was particularly important to Individual #107 due to medications administered via G-tube. The nurse did attempt to provide as much privacy as possible in the space available by placing the medication in a narrow hallway off of the dining area. The nurse explained she also attempts to block the view with her body. The privacy screen was reported to be too difficult to manage with the medication cart that could not be left unattended, particularly without the assistance of the direct care professionals. During the administration another individual was constantly rolling back and forth in the hallway where the medication cart was located. The direct care professionals did not assist nor were they asked to assist or keep the other individual away from the medication cart while medications were being administered. This not only prevented privacy for the individual receiving medication but was an obvious distraction to the nurse while medications were being administered. Such distractions have the potential to cause medication errors. Review of the information related to medication errors bear out this fact, as discussed later in the report.	

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		• The medication nurse (agency nurse) administering medications orally to individual #419 in Timberhill 508, did not consistently follow correct medication administration procedures: o After cleansing hands with hand sanitizer the medication nurse wore the same gloves throughout the entire medication pass. While it was acceptable to wear gloves when applicable during medication administration, wearing gloves did not suffice for washing hands. The location of the medication cart was not accessible to hand washing facilities. The use of hand sanitizers are no substitute for washing hands with soap and water. o Failed to complete the "three basic medication checks" before administering medications e.g., check medication labels against the MAR three times (when removing the medications from the supply drawer, when placing the medication in an administration cup/syringe, and when replacing the medication back in the supply drawer or prior to disposing the empty medication package) before administering medications to individuals. o Failed to proved adequate privacy for individual #419 receiving medication. The medication cart was located between the residential living room and dining area. A privacy screen was used to block the view from the living room but not the dining room where other individuals were present. The direct care professionals did roll the individual up to the medication cart to received medications. o Failed to inform individual #419 what medications she was administering, and their purpose. When prompted, she did tell the team member the names and purposes of the medication she was administering. o Failed to implement individual #419's Self-Administration Plan. The medication nurse marked the Self-Administration before administering. o Failed to review the individual's Medication Administration Sheet for instructions regarding alteration in consistency, texture, dining presentation, adaptive equipment, and/or positioning dated 9/15/10. Instructions were to mix pills in pudding and then follow with honey thickened liquid. The medications administered were mixed with pudding and administered without difficulty. This individual was scored at high risk for aspiration. After administering the medication the medication nurse failed to provide a honey thickened drink. The medication nurse was prompted by monitoring team to provide liquids. As the individual was rolled away from the medication cart the medication nurse asked the direct care professional to give individual #419 liquids to drink. The monitoring team member did not observe the direct staff providing liquids. The medication nurse's poor performance was discussed with the CNE and NOO. This medication nurse needed to be retrained in correct medication	

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		procedures. After reviewing all residential units' space available for nurses to administer medications, interviewing nurses, during Medication Administration Observations and review of MARs; numerous concerns were identified: • Lack of space for medication nurses to administer medications safely and effectively. This was the most significant concern identified. The lack of space for nurses to administer medications was identified in the baseline review. At the baseline review during medication administration observations the nurses consistently and effectively used privacy screens and the direct care support staff assisted the nurses by bringing individuals to the nurse for medication. This practice was not implemented during the observations at this review. According to the Medication Administration Committee Minutes, March 11, 2010, the CNE was to convene a building space committee to begin obtaining dedicated spaces for medication administration. This was also indicated in the Facility's POI and interview with the CNE and NOO. They reported that a Space Committee had been formed to study space. There was no evidence provided to validate that progress had been made in providing a dedicated space for medication administration. The Facility needs to provide space for administering medications in each living area that affords privacy for individuals, a quieter, calmer environment that promotes teaching of the individuals, freedom from distractions that has the potential to cause medication errors, and provide hand washing facilities. • The residential nurses interviewed expressed the difficulty they had in using privacy screens while managing medication carts since they cannot leave medication carts unattended while moving the screens. Therefore, they had mostly abandoned the use of the privacy screens. Instead they stated they used the medication carts and their bodies to block the view. This practice was acceptable according to DSSLC's Medication Administration Policy. This method of providing privacy was neither an acceptable method nor practical method to use in the open residential living areas. This method of providing privacy needs to be discontinued and the practice of using privacy screens needs be used with the assistance of the direct are staff until such time that functional and dedicated spaces are provided to administer medications and/or treatments. • The lack of space also presented an infection control problem because of inaccessibility to facilities for washing hands with soap and water. Nor was it practical for the medication nurses to stop medication administration during heavy medication passes to lockup the medication carts and move them to an area where their hands could be washed with soap; this would significantly delay medication passes. While the use of hand sanitizers was acceptable they	

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		are no substitutes for washing hands with soap and water. Additionally, after using the hand sanitizers three or four times the hands become sticky and uncomfortable. Most hand sanitizer manufactures specify the number of times the sanitizers can be used for washing with soap and water. Most heath care facilities specify in their Medication Administration Policies how many times the hand sanitizers can be used before nurses were required to wash with soap and water. The Infection Control Nurse needs to monitor and evaluate the practice of nurses using hand sanitizers while administering medications and treatments as opposed to using soap and water to ensure that nurses' cleansing of hands meet infection control guidelines. The MARs reviewed did not consistently contain a copy of individuals' PNMP. In the MARs reviewed in Timberhill 508 there were several copies of PNMPs in individuals MARs and it could not be discerned which version was current. The PNMPs reviewed did not include specific instructions for medication administration for individuals who had identified needs for alterations in consistency, textures, food presentation, adaptive equipment, and/or positioning. It was equally important that individuals with the need for such alterations receive their medications accordingly. The Nursing Department and PNMT needs to ensure that individuals requiring alternations in consistency, textures, food presentation, adaptive equipment, and/or positioning have a current PNMP placed in their MARs, nurses are trained to refer to the PNMP during medication administration, and their use monitored by the Nurse Managers or designee. The MAR Count Sheets reviewed indicated that medications were not counted consistently and/or error counts were not correct. The practice of using Medication Count Sheets was an excellent method for preventing medication errors and/or identifying medication errors timely. The Nurse Case Managers need to increase their MAR audits to include monitoring the Medication Count Sheets for completeness and accuracy and take corrective action with nurses who fail to count or count incorrectly. September, 2010, MARs for individuals #381, #534, #433, and #621 revealed handwritten numbers, by nurses without initials, beside medications printed on the MAR indicating the number of pills required to make the complete dose of medications printed on the MARs. This practice was a concern because it could be misleading and had the potential to cause medication errors that could result in harm to individuals. This issue was discussed with the medication nurses, CNE, NOO, and Pharmacist all of which agreed this practice had contributed to medication errors. It was explained that handwriting the number of pills was necessary because the Pharmacy's WORx system can only print so many lines and it was not possible to print the number of pills required to make the prescribed dose for particular medications requiring more than one pill. Findings from	

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		review of the MARs included: • Individual #381's MAR had handwritten number of pills required to complete the prescribed medication doses: o Allopurinol tablet, 200 mg, G-tube; twice a day, for Hyperuricemia. Handwritten give "2 tabs" because the pharmacy dispensed 100mg tablets. If a nurse administering the medication misread or misunderstood what "2 tabs" meant it could have been misconstrued and interpreted to mean give two 200mg of the medication, as opposed to giving two 100mg tablets. o Allopurinol tablet, 200 mg, G-tube; twice a day, for Hyperuricemia, was not initialed on 9/25/10 at 0700. The omission was not circled, nor was there documentation on the back of the MAR explaining reason the medication was not initialed. This represented a medication error that should have been reported and corrective action taken with the nurse omitting the charting. o Phenytoin tablet chew, 50mg, G-tube, a.m. and p.m.; for seizures. Handwritten give "2 tabs". If a nurse administering the medication misread or misunderstood what "2 tabs" meant it could have been misconstrued and interpreted to mean give two 100mg of the medication as opposed to giving two 50mg tablets that was dispensed. • Individual #433's MAR had handwritten number of pills required to complete the prescribed medication doses: o Carbamazepine tablet chew 300mg; for seizures. Handwritten give "3 tabs". If a nurse administering the medication misread or misunderstood what "3 tabs" meant it could have been misconstrued and interpreted to mean give three 300mg of the medication as opposed to giving three 100mg tablets that was dispensed. • Individual #621's MAR had handwritten number of pills required to complete the prescribed medication doses: o Phenytoin tablet chew, 100mg, G-tube, at noon; for seizures. Handwritten give "2 tabs". If a nurse administering the medication misread or misunderstood what "2 tabs" meant it could have been misconstrued and interpreted to mean give two 100mg of the medication as opposed to giving two 50mg tablets that was dispensed. o Phenytoin tablet chew, 150mg, G-tube, at bedtime; for seizures. Handwritten give "3 tabs". If a nurse administering the medication misread or misunderstood what "3 tabs" meant it could have been misconstrued and interpreted to mean give three 150mg of the medication as opposed to giving three 50mg tablets that was dispensed.	

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		Another concern was identified while reviewing MARs. New Physician Orders for medications and treatments prescribed after MARs were printed must be handwritten onto the MARs, particularly new medications prescribed at or the near the end of the month after the next months MARs had been printed. This issue was discussed with the medication nurses, CNE, NOO, and Pharmacist all of whom agreed this practice had contributed to medication errors because the nurses must carry forth new medications ordered at or near the end of the month onto the new MARs. Occasionally nurses failed to carryover the new orders on the new MARs, causing medication errors of omission. It was explained that this practice was necessary because the Pharmacy's WORx system cannot reprint the MARs to accommodate the new medications prescribed. Reviewed individual #206's MAR for September 2010 that had blank spaces without a circled explanation for the omission of the medications: • Baclofen Tablet, 10 mg, per tube, three times a day, morning, noon, and bedtime; for spasticity was not documented on 9/20/10 at 2020 and 9/26/10 at 1200. • Calcium/Vit. D 250/125 tablet, two tablets per tube, at noon and evening; for osteoporosis was not documented on 9/20/10 at 1630. • Esomeprazole Mag+ Suspdr Pkt, 40 mg, every morning; for severe gastritis/reflux was not documented on 9/2/10 at 0800. • Multivitamins tablet, noon; for nutritional supplement was not documented on 9/26/10. Since the baseline visit in April 2010 the Nurse Case Managers began monitoring MARs monthly. This was a positive finding. The Facility needs to ensure when medications were not initialed on the MAR that Medication Error Reports are completed and corrective action taken with nurses committing omissions. The Nursing and Pharmacy Departments need to evaluate the practice of nurses' handwriting corrections or explanations on MARs and require the nurses to return MARs to the Pharmacist to write the necessary corrections and/or explanation on the MARs. The 10 most recent medication errors, 8/1/10 through 8/29/10, received through the document request were reviewed. The review revealed the following findings: • One medication error was scored on the Severity Index as Category A: Circumstances or events that have the potential to cause error. • Two medication errors were scored on the Severity Index as Category B: An error occurred but the medication did not reach the individual. • Seven medication errors were scored on the Severity Index as Category C: An error occurred that reached the consumer but did not cause the individual harm. • Eight medication errors were discovered within 24 hours or less after the error occurred. This was a positive finding since the baseline review.	

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		• Two errors were discovered three days after error occurred. • Ten of 10 (100%) medication errors were reported to the respective physician within 24 hours or less. • Nine of ten (90%) medication errors indicated that the Nurse Case Manager or designee took corrective actions with the nurses committing the errors. Two of the nine (22%) nurses received corrective action within 24 hours or less. Seven of nine (78%) nurse did not receive corrective action within 24 hours. Corrective action for these medication errors did not occur from two days to as long as 14 days after the error occurred. It was critical that nurses who commit medication errors have corrective action taken as soon as the errors are discovered in order to prevent future occurrences. The Nursing Department needs to ensure that corrective actions are taken promptly with nurses committing medication errors when medication errors are discovered. • One of ten (10%) Medication Error Report documentation indicated that in addition to the error reported, two other of the same type errors were discovered regarding administering dose of Tylenol #3 at the wrong time to individual #365. There was no documentation on the report indicating that the three nurses committing the errors received corrective action, nor were there Medication Errors Reports of the two additional errors available for review; therefore it could not be discerned if Medication Error Reports were completed. The Nursing Department needs to ensure that when multiple medication errors are discovered on a Medication Error Report that those errors are reported. The Facility and State Office need to evaluate the WORx system's inability to print the necessary number of lines for each medication entered on the MAR and clearly describe instructions for medication administration, and the inability to reprint MARs to include new medications prescribed at or near the end of the month in an effort to prevent medication errors. The monitoring team reviewed Medication Error Committee Minutes for 3/11/10, 3/26/10, 4/20/10, 6/11/10, 6/25/10, 7/9/10, 9/23/10, 7/30/10, and 8/13/10. Reportedly the Medication Error Committee was to meet weekly. According to DSSLC Supplemental POI, Nursing leadership meets minimally every other week to address medication errors. A monthly med error meeting takes place which includes nursing leadership, QA nurse, pharmacy and other disciplines as recommended indicated. Trends are presented at this meeting (provided by Wes Knox). Med errors are also discussed at P & T. The 3/11/10 minutes indicated that the CNE began to convene a building space committee to obtain dedicated spaces for the nurses to administer medication. The minutes through 8/11/10 continued to report that the space committee was working on locating space but failed to report the status of locating space. At the time of the tour no	

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		dedicated place had been provided in any of the residential units for nurses to administer medication. When the monitoring team asked about the status of the report, the CNE and NOO stated the Facility was still working on locating space but no projected date was provided. The lack of space in the residential units was identified at the baseline visit and continued to be a major concern identified in this review, as was discussed above. The Medication Error Committee Meeting Minutes reviewed indicated the Committee put forth significant effort in analyzing medication errors and making recommendations for corrective action. According to the minutes if nurses made two or more medication errors per year, the Medication Error Committee reviewed the numbers of medication errors they committed and decided on corrective actions. The minimum corrective action was to send the nurse to the Nurse Educator for re-training. Such action was validated throughout the Medication Error Committee Reports. The minutes included a list of medication errors by residential units and nurses committing the errors as well as corrective actions taken. The minutes indicated that the primary factors contributing to medication errors were: Distractions during medication administration, errors committed by agency nurses, inadequate nursing staff to pass large volumes of medications, and transcription errors. The CNE reported that every effort was being made to reduce and/or eliminate the use of agency nurses due to the high percentage of medication errors they committed. While the minutes stated that Medication Error Trending Reports were reviewed, such reports were not available to the monitoring team for review. The Medication Error Committee attendance sheets did not include medication nurse representatives. The Medication Error Committee needs to consider the addition of medication nurse representatives in order to assist them in gaining insight into issues surrounding medication errors and to assist with problem solving. Additionally, review of the various Nursing Meeting Minutes, February, 2010, through August, 2010, failed to include information from the Medication Error Committee regarding findings and discussions relevant to preventing and/or reducing medication errors, with the exception of reminding nurses to double check MARs every shift for missed initials. The Nursing Department needs to ensure that Medication Error Committee Meeting findings and discussions relevant to preventing or reducing medication errors are included in Nursing Meetings. The monitoring team reviewed monthly Pharmacy and Therapeutic Committee Meeting Minutes for 4/28/10, 5/19/10, 6/23/10, and 7/26/10. Only two of the Pharmacy and Therapeutic Committee minutes included information specific to medication errors committed by nursing staff. At the 4/28/10 Committee meeting the NOO presented the Medication Error Committee Minutes. Those minutes failed to provide a detailed description of number and type of errors. The NOO reported that the Medication Error Committee for nursing decided if medication errors were greater than two per year for	

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		any nurse the Committee would decide on the action to be taken. The NOO further reported that most medication errors were due to disruptions. Lack of adequate space for administering medication continued to be problematic. The space committee continues to meet in an effort to find available to utilize for medication administration or storage. At the 6/23/10 Committee meeting the NOO reported there were 50 omission errors reported in the past quarter of which 27 were committed by one nurse. The three nurses who made the greatest number of medication errors were reported to be agency nurses who were no longer employed. Other nurses committing medication errors were sent to the Nurse Educator for re-training. The NOO continued to report that the space committee was looking for areas the nurses could utilized to administer medications with limited interruption to assist with decreasing medication errors. In the 4/28/10 Pharmacy and Therapeutic Committee Minutes, the Pharmacist reported and described that there were 32 dispensing errors. This represented less than 0.1% of the 33,600 doses dispensed weekly. No recommendations for improvement were contained in the report. In the 5/23/10 Committee meeting the Pharmacist reported fifteen Pharmacy dispensing errors. These were reported, described, and problem solving measures discussed including, having another pharmacist check the other pharmacist order entry if the trend continued. The remaining Pharmacy and Therapeutic Committee Meeting minutes did not include data or discussion regarding medication errors. It was of concern that minutes did not reflect that the Pharmacy and Therapeutic Committee had explored in-depth the underlying reasons for medication errors committed by the nursing staff and dispensing errors committed by the pharmacy staff as well as exploring problem solving measures to prevent and/or reduce these two types of errors. The Pharmacy and Therapeutic Committee needs to more aggressively explore the underlying causes for all types of medication errors and explore problem solving measures to prevent and/or eliminate errors. Refer to Section N for additional information regarding the Pharmacy and Therapeutic Committee Meeting Minutes. The Facility's Performance Improvement Council Meeting Minutes, 8/18/10, reported that the number of medication errors by omission went down from 35 to eight and the number of medication errors by wrong time went down from 34 to one. While this was a positive finding reported in the Performance Improvement Council, it failed to describe the timeframe over which the medication errors had occurred or address other forms of medication errors or actions to be taken to further reduce the occurrence of medication errors. The Facility's Performance Improvement Council needs to take an active role in problem solving medication errors, particularly as related to finding dedicated spaces in the residential areas for nurses to pass medication that affords individuals privacy, freedom from distraction while passing medications, and provide facilities for nurses to wash their hands.	

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		Reviewed data for tracking, trending, and analyzing medication errors provided through the document request. The medication error data were presented in tabular and graphic form and were only specific to Pharmacy dispensing errors. The system used was difficult to interpret and to drawn a clear understanding of the data represented. Medication error data for tracking, trending, and analyzing medication errors specific to nursing were not included in the information available for review. The manner in which data were represented was discussed with the Pharmacy Director who agreed the system used was difficult to interpret and needed to be revised. Information in the Facility's QA/QI Council Meeting: Data Analysis Report, 9/23/10, contained a graph representing medication error data from March, 2010, through August, 2010, with a notation that medication errors were up in August to 17 from 10 in July. However, the data weres too limited to drawn any conclusion regarding their significance. Therefore, it was not possible to accurately discern the number, types and contributing factors that led to medication errors from the tracking, trending, and analysis data available for review. The Nursing Department and Pharmacy Department need to revise the system used for tracking, trending and analyzing medication error data into a format that captures all forms of medication error data; one that can be easily interpreted, and used to make improvements in medication administration and dispensing practices.	

Recommendations:

1. The Facility's Chief Nurse Executive should continuously evaluate nursing staffing demands because of an aging population compounded by many individuals who have co-morbid conditions. Therefore, individuals who reside at the Facility have the potential to require increased health care over time.
2. The Facility's Nurse Educator needs to develop and implement a system for tracking all required training to ensure that 100% of the nurses receive the training and that training was completed within the specified time frame.
3. The Nursing Department needs to re-train all staff nurses in the Aspiration Pneumonia Clinical Protocol and vomiting Protocol. The Nurse Managers should monitor nurses for adherence to these two protocols.
4. The Facility's Nursing Department and the State Office need to revise the Medication Administration Policy in accordance with the Settlement Agreement and Health Care Guidelines.
5. The Facility's QA Department in collaboration with the Nursing Department needs to develop and implement operational procedures or interpretative guidelines for the adopted and implemented Settlement Agreement Monitoring Tools to ensure consistency among the auditors as well as an inter-rater reliability procedure to ensure that reliable data are produced. A system needs to be established for tracking, trending, and analyzing data over time to ensure substantial compliance. Further, the system needs to include tracking to ensure that each nurse was observed at least quarterly.
6. The Facility's Nursing Department needs to develop a Nursing Peer Review Committee that reviews and analyzes audit data derived from the peer reviews in an effort to identify and solve problematic areas of nursing practice as a means to improve the quality of nursing services provided.
7. The Facility's Nursing Department needs to ensure that the "P" component of SOAP notes describes precisely what physician's order's, nursing management, and monitoring will be carried out.

8. The Facility's Nursing Department needs ensure that nurses document the method used for taking temperatures.
9. The Facility needs to review and update the Abbreviation List.
10. The Facility needs to ensure that all records include individuals' name and/or identification number.
11. The Facility should evaluate the functional order of the records to ensure continuity of nursing data and develop a user friendly tab system, using larger tabs for nursing data that can be easily read and found.
12. The Nursing Department need to ensure that nurses complete lung assessments after individuals vomit due to the high risk for aspiration pneumonia. The Nurse Educator needs to competency-base re-train nurses on the Aspiration Clinical Protocol and Vomiting Protocol. The Nurse Educator needs to train the nurses on the signs, symptoms, and management of sepsis.
13. The Facility's Medical and Nursing Departments need to re-evaluate their protocol as to when to notify the physicians regarding signs and symptoms of acute illnesses and injuries.
14. The Facility's Nursing Department needs to ensure that RN Case Managers continue to improve the quality of nursing assessments in the following areas:
    - Ensure that all active health/medical problems have Health Maintenance Plans, including those determined stable and/or may not be listed as high or medium risk.
    - Analyze the effectiveness of each HMP in the Nursing Summary. If not effective, state what changes need to be made to the HMPs.
    - Ensure that Nursing Summaries include comparisons of health or behavior issues identified between quarters to assess if the individual's' health status was improving, maintaining, or regressing, and if there was progress or lack of progress in attaining measureable objectives, services, and/or supports that were included in the HMPs.
    - Ensure that individuals' therapeutic response to psychoactive and/or anticonvulsant medications are included in the Nursing Summary, particularly when new medications are prescribed and/or doses are adjusted up or down. Also include results of MOSES and DISCUS, and lab values.
    - Ensure that the status of individual's Self Administration of Medication Program is included in the Nursing Summaries.
    - Ensure that that Annual and Quarterly Comprehensive Nurses Assessments are sent to the Qualified Mental Retardation Professional and other relevant PST members.
15. The Infection Control Nurse needs to ensure that staff are aggressively monitored for proper hand washing, use of Standards Precautions when indicated, as well as Environmental Surveillance monitoring.
16. The Facility's Pneumonia Work Group should evaluate the correlation of the incidents of aspiration pneumonia with the precursors of vomiting episodes prior to developing aspiration pneumonia.
17. The Facility needs to develop and implement a tracking system for vomiting. The Nurse Managers or designees and PNMP need to monitor vomiting tracking data to ensure that vomiting is addressed promptly.
18. The Nurse Educator in collaboration with the PNMT should consider developing and implementing a training module for vomiting, to include potential causes of vomiting, risk of aspiration pneumonia secondary to vomiting, how to describe, respond, report, and document. This training needs to be mandatory for all staff having direct responsibility for individuals' care.
19. The Pneumonia Work Group should consider analyzing pneumonia data related to the method of administration of nourishment or medication. The comparison should be made for those who were diagnosed with aspiration pneumonia versus the entire pneumonia data that includes all types of pneumonias. This should provide a more accurate picture as to whether individuals receiving enteral routes of administration of nourishment and medication were more or less at risk for aspiration pneumonia than individuals receiving oral intake. Analyzing data from this perspective should provide valuable information to use in planning interventions to minimize the incidents of aspiration pneumonia.
20. The Facility's professional staff responsible for reporting and entering pneumonia data into the Pneumonia Tracking system need to ensure that all diagnosed cases, by type, of pneumonia are accurately reported.
21. The Facility's Skin Integrity Committee needs to trend and analyze data stratified to identify contributing factors causing pressure ulcers and that

could be used by applicable integrated team members to make clinical decisions. This could be integrated into the Facility QA system. The Facility could use this information to plan preventative measures to reduce the incidents of pressure ulcers.

22. The Facility's Skin Integrity Nurse and Occupational Therapist need to ensure that acute care plans are developed for individuals with pressure ulcers. The plans should meet individuals' unique needs to promote healing and prevent further pressure ulcers as well as ensure that direct care staff are adequately trained.
23. The Facility's Skin Integrity Nurse needs to continue training nurses on how to assess and document the size, appearance, and status of healing of pressure ulcers.
24. The Facility's PSP, HST, and/or PNMT must meet promptly after individuals are diagnosed with aspiration pneumonia to review precursors that might have lead to the aspiration pneumonia. The PSP, HST, and/or PNMT should re-evaluate individuals' Health Risk for aspiration and the effectiveness of their plans of care to prevent future episodes of aspiration pneumonia.
25. The Facility's Occupational Therapist needs to ensure when PNMCs are instructed to monitor individuals that they follow through and document their actions in the Integrated Progress Notes.
26. The Facility's Occupational Therapist and/or Dietitian should respond timely after receiving a referral from the Skin Integrity Nurse to assess individuals with pressure ulcers.
27. The Nursing Department needs to ensure that abdominal assessments are completed correctly with the individuals in a reclining position so that the abdomen can be adequately ascultated and palpated.
28. The Facility's Infection Control Nurse, Quality Assurance Nurse, Nurse Educator, Medical Director, and other related interdisciplinary teams need to analyze and trend death reported data for causative factors contributing to deaths in an effort to develop and implement effective strategies to reduce the incidents of infectious diseases that may be causative factors contributing to the high number of deaths at the Facility.
29. The Facility's Nursing Department should consider reinforcing the use of SBARS (situation, background, assessment, recommendations and, summary) Report to a Physician method of reporting to physicians.
30. The Facility's Nurse Case Managers need to increase their MAR audits to include monitoring the Medication Count Sheets for completeness and accuracy and take corrective action when nurses fail to count or count incorrectly.
31. The Facility's Nursing Department needs to ensure that corrective actions are taken promptly when medication errors are discovered.
32. The Facility needs to provide space for administering medications in each living area that affords privacy for individuals, a quieter, calmer environment that promotes teaching of the individuals, freedom from distractions that has the potential to cause medication errors, and provide hand washing facilities.
33. The Facility's Nursing Department needs to discontinue the practice of nurses using medication carts and their bodies to provide privacy during medication administration and/or treatments and use privacy screens with the assistance of the direct are staff until such time that functional and dedicated spaces are provided to administer medications and/or treatments.
34. The Facility's Infection Control Nurse needs to monitor and evaluate the practice of nurses using hand sanitizers while administering medications and treatments as opposed to using soap and water to ensure that nurses cleansing of hands meet infection control guidelines.
35. The Nursing Department and PNMT need to ensure that individuals requiring alterations in consistency, textures, food presentation, adaptive equipment, and/or positioning have a current PNMP placed in their MAR, nurses are trained to refer to the PNMP during medication administration, and their use is monitored by the Nurse Managers or designee.
36. The Facility's Nurse Case Managers need to ensure when medications are not initialed on the MAR that Medication Error Reports are completed and corrective action taken with nurses committing to omissions.
37. The Facility's Nursing and Pharmacy Departments need to evaluate the practice of nurses handwriting corrections or explanations on MARs and require the nurses to return MARs to the Pharmacist to write the necessary corrections and/or explanation on the MARs.
38. The Facility and State Office needs to evaluate the WORx system's inability to print the necessary number of lines for each medication entered on the MAR andto clearly describe instructions for medication administration, and the inability to reprint MARs to include new medications prescribed

at or near the end of the month in an effort to prevent medication errors.

39. The Facility's Nursing Department needs to ensure that when multiple medication errors are discovered on a Medication Error Report that those errors are reported.
40. The Medication Error Committee should consider the addition of medication nurse representatives in order to assist them in gaining insight into to issues surrounding medication errors and to assist with problem solving.
41. The Nursing Department should ensure that Medication Error Committee Meeting findings and discussions relevant to preventing or reducing medication errors are included in Nursing Meetings.
42. The Facility's Pharmacy and Therapeutic Committee needs to more aggressively explore the underlying causes for all types of medication errors and explore problem solving measures to prevent and/or eliminate errors.
43. The Facility's Performance Improvement Council needs to take an active role in problem solving medication errors and should review issues related to finding dedicated spaces in the residential areas for nurses to pass medications that afford individuals privacy, nurses' freedom from distraction while passing medications, and provide facilities for nurses to wash their hands.
44. The Facility's Nursing Department and Pharmacy Department need to revise the system used for tracking, trending and analyzing medication error data into a format that captures all forms of medication error data; one that can be easily interpreted, and used to make improvements in medication administration and dispensing practices.

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. Denton Plan of Improvement (POI) 5/17/10 2. Denton Supplemental Plan of Improvement (SPOI) 7/6/10 3. Quarterly Drug Regimen Reviews 4. The following documents for individuals #151, #411, #571, #639, #373, #490, #505 were reviewed: • PSP • Quarterly Pharmacy Reviews • Annual Pharmacy Reviews • Moses • DISCUS • PSP • Addendum to PSPs • Previous 12 months labs • Quarterly nursing assessments **People Interviewed:** 1. Rosha Chadwick, RPh, Director of Pharmacy **Meeting Attended/Observations:** None
	Facility Self-Assessment: The Facility reported being in compliance with most Action Steps of its Plan of Improvement (POI). The monitoring team did not concur with many of those findings. The Facility reported that it had documentation of communication between the pharmacist and provider, including documentation that medication was not dispensed until the pharmacist's concerns about a physician's order for medication was resolved. Examples were identified where important and clinically relevant recommendations were provided by the pharmacist; however, when reviewed and considered by the physician, no action was taken, just acknowledgement of the recommendation and no clinical rationale documented as to why the recommendation was not followed. Communication alone does not ensure that the purpose of the communication is met. The Facility reported that pharmacists and physicians collaborate on a number of issues, including monitoring of benzodiazepines and anticholinergics, but the monitoring team determined the Facility did not have an active, meaningful process to adequately monitor these. The Facility reported that tardive dyskinesia is monitored appropriately. Scheduled MOSES and DISCUS

	assessments were completed to measure side effects including tardive dyskinesia; other regular review for emerging side effects was not noted.
	Summary of Monitor's Assessment: Significant effort had been made to enhance pharmacy services. Meaningful review processes had been developed to ensure medication was not dispensed in the event of an interaction or known side effect. However, when pharmacists made recommendations, physicians often reviewed them but took no action and provided no rationale for not acting on the recommendation. Occasional examples of inappropriately completed physician's orders were identified. Procedures need to be refined to ensure all orders are reviewed by the pharmacist and any issues addressed. QDRRs were completed timely, but action was not always taken on recommendations by the pharmacists, and justification for not accepting recommendations was not always documented. Quarterly MOSES and DISCUS reviews were done timely, but more intense monitoring for side effects were initiated in clinically relevant situations, such as when a new medication was added, an individual's condition worsened, or when abnormal laboratory monitoring was noted. The Facility did not have a process in place that ensured a timely identification, reporting and follow up remedial action regarding all significant or unexpected adverse drug reaction. Although the pharmacy had developed a new system to review medication variances identified by the pharmacy, the pharmacy system was not integrated into a process that was responsible for the total oversight of medication variances.

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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	A comprehensive review of pharmacy services was conducted on September 30th, in collaboration with the Facility's Director of Pharmacy, Rosha Chadwick, RPh. During the review, the review team was provided evidence that indicates that significant effort had been made to enhance pharmacy services. The director of pharmacy developed meaningful review processes that helped to ensure that medication was not dispensed in the event of a drug-drug interaction or known side effect. Currently the facility had one clinical Pharmacist who was responsible for conducting all quarterly and annual reviews for the Facility. Dispensing pharmacists were responsible for ensuring that prescriptions were completed appropriately and monitored for drug-drug interactions, known side effects and appropriate dose and indication. There were policies in place and mechanisms to alert physicians of the clinical pharmacist's concerns following a quarterly or annual pharmacy review. Upon review, occasional examples of inappropriately completed physician's orders were identified by the monitoring team including orders that were not timed, included off-	N

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	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.	label prescribing without justification, and had known allergies not listed on the order. Importantly, off labeled uses of medications were dispensed without appropriate diagnosis noted on the order or the clinical rationale noted in the integrated progress note. The director of pharmacy recognized that the current processes require additional refining to ensure that 100% of orders are reviewed and any issues addressed by the dispensing pharmacist in a clinically appropriate manner. Specific to pharmacy reviews, the Facility's single clinical pharmacist was responsible for reviewing all individuals. Given the number of individuals served, this would enable only a cursory review and did not enable assertive assessment of more frequent monitoring of drug levels and monitoring of side effects. Of the records reviewed, QDRRs were noted to be timely. Upon discussion with the director of pharmacy services, there were concerns about collaborative efforts with the medical staff; in general, the clinical pharmacist did not assertively address potential concerns that were initiated by the pharmacy and rejected by the physician. In other words, if the pharmacist made a recommendation and the physician disagreed, no further action was taken and the order was processed. Upon review of Quarterly Drug Regimen Reviews (QDRRs), some reviews were not comprehensive and did not address potentially serious issues. The quarterly pharmacy review of Individual #250 indicated that the individual was prescribed and administered Alondronate on a regular basis for osteoporosis. In this particular case, Alondronate is an off-labeled use in male patients and appropriate consents and review by the personal support team were not initiated. More important, the individual was known to have significant gastrointestinal risk factors, which included a history of gastritis, severe periodontal disease and gastroesophageal reflux disease. The review process should have significantly addressed these issues. Clinical review of individual #413 revealed that the individual was prescribed Lithium for bipolar hyperactivity, which is an off labeled use. The dispensing pharmacists and the clinical pharmacist did not address this issue prior to dispensing or at the time of the pharmacy review. An order was written to decrease the lithium by 50%, however, no orders were noted to ensure that a follow-up lithium level was ordered to ensure that the drug levels remained therapeutic.	
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-	Individual #342 was prescribed and administered Risperidone daily. Levoquin was added to her daily medications for pneumonia. The pharmacists notified the physician that there existed a potentially serious drug-drug interaction among Risperidone and Levoquin that could result in fatal cardiac arrythmias and that clinical monitoring was indicated. The physician responded by stating that "the hospital recommended it for aspiration pneumonia". No further follow-up was initiated by the pharmacist and the	N

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	therapeutic medication values.	order was completed.	
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.	Upon review of STAT medications and chemical restraints, it was noted that the Facility did not have an adequate sample size to review. There had been no use of chemical restraint. However, during discussion with the director of pharmacy services, the monitoring team was made aware that the Facility did not have an active, meaningful process to adequately monitor the use of benzodiazepines and anticholinergics. A comprehensive and clinically relevant mechanism to monitor for metabolic system is currently not in place at the Facility.	N
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.	Specific to the physicians' review of the pharmacists' recommendations, there was considerable disconnect between the pharmacists and physicians. Many examples were identified where important and clinically relevant recommendations were provided by the pharmacist; however, when reviewed and considered by the physician, no action was taken, just acknowledgement of the recommendation and no clinical rationale documented as to why the recommendation was not followed. Although the Facility did have appropriate policies in place to address this issue, the actual process was not functional. The physician must appropriately address the pharmacist's recommendation and either adhere to the recommendation, if clinically indicated, or provide well documented clinical rationale as to why the recommendation is not followed. Conversely, it is the pharmacist's responsibility to ensure that he/she is well aware of the clinical issues and assure that recommendations are clearly indicated.	N
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as	MOSES and DISCUS instruments were noted and completed within the clinical records. Of the seven records reviewed, there were no cases identified that indicated more intense monitoring for side effects was initiated in clinically relevant situations, such as when a new medication was added, an individual's condition worsened, or when abnormal laboratory monitoring was noted. To be compliant with this provision, the	N

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	MOSES or DISCUS), of tardive dyskinesia.	Facility must ensure that not only are assessment tools present in the clinical record, but that they are meaningfully utilized by staff to monitor for the insidious development of side effects. Nurse managers at the Facility are responsible for completing the assessment tools; however, other nursing staff were unaware of the tools, how they are used, what purpose they serve or even their existence or placement in the clinical record. Appropriate completion of the MOSES and DISCUS is essential. In one particular case, an individual was noted to have an increase of DISCUS score from 3 to 4. The DISCUS was signed off by the nurse and the nurse indicated no change in DISCUS score in the progress note. The DISCUS was signed by the physician with no concerns noted in the clinical record.	
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.	Following a lengthy discussion with the director of pharmacy, it was determined that the Facility did not have a process in place that ensured a timely identification, reporting and follow up remedial action regarding all significant or unexpected adverse drug reaction. In fact, the Facility did not have a process that enabled direct care staff, nursing staff, or medical staff to routinely monitor individuals for adverse side effects other than scheduled MOSES and DISCUS monitoring. Additionally, the review team was informed by the Director of Pharmacy that the Facility did not have a process in place to regularly monitor individuals for metabolic disorder as a component of significant adverse drug reactions.	N
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.	The Facility currently had a procedure in place to conduct regular utilization reviews of medication use at the Facility; however, it had not yet been fully implemented. The current process did not have a standardized mechanism that ensured both a randomized and specific inclusion of medications to be reviewed through the utilization process. The review of the use of antibiotics, psychotropics, high frequency medications, and drugs with narrow therapeutic and toxicity windows should routinely be included in the utilization process, as should a randomized selection of other medications be included, or when a drug is implicated in a serious adverse outcome or over utilized by physicians.	N
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular	The clinical pharmacist had developed and implemented a system to review actual medication variances identified by the pharmacy. There were no cases available for review because no variances had been recently identified. Following discussion with the director of pharmacy, several issues were identified as problematic. The review process	N

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	documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	was divided up among different disciplines with pharmacists reviewing pharmacy activities, nurses reviewing nursing activities, and physicians reviewing physician activities, and the pharmacy system was not integrated into a process that was responsible for the total oversight of medication variances.	

Recommendations:

1. A comprehensive drug variance program must be immediately developed that includes analysis of inappropriate prescribing, dispensing, administration and storage of medications at the facility. Data must be maintained longitudinally and should be compared with national norms.
    a. The Facility must develop a robust mechanism at the living area to monitor for medication administration errors.
    b. The Facility must develop a mechanism that assesses physician prescribing issues, such as prescribing medications where there is a known or suspected allergy, contraindication or potential drug-drug interaction.
    c. Pharmacy should review its process of reviewing variances with national standards for long-term care systems.
    d. Medication variances must be reviewed regularly by the Facility and there should be a single body and well identified leadership to oversee all medication variances.
2. The utilization review process must be immediately enhanced to ensure that appropriate medications are reviewed on a regular basis.
3. The Facility must develop a mechanism to regularly assess individuals for adverse drug reactions. Direct care staff, nursing staff and physicians must all play an active role in the process.
4. It is imperative that all clinical staff be well aware of drug monitoring tools, how they are used, how to interpret their results, where they are located in the clinical record and how to follow-up on abnormal results.
5. Physicians, Nurses and Pharmacists must begin working together collaboratively. Each are equal professionals that together provide health care services to individuals served. Recommendations from one professional entity must be appreciated by the others and if there are persistent disagreements, consultation by the Facility's clinical leadership should be sought.
6. Quarterly and annual pharmacy review must be enhanced by ensure a more in-depth review and with accuracy.
7. It is imperative that the Facility develop a comprehensive metabolic screening program to better monitor individuals for metabolic syndrome, especially for individuals on atypical antipsychotics.

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**: 1. DSSLC Plan of Improvement, (POI) 5/17/10 2. DSSLC Supplemental Plan of Improvement (SPOI), 7/6/10 3. Records reviews for: Individuals #11, #129, #135, #147, #185, #186, #211, #220, #242, #259, #289, #308, #309, #323, #326, #342, #350, #387, #390, #485, #457, #495, #565, #571, #595, #602, #639, #654, #701, #741, #743, #768, #776, and #779, 4. A list of all therapy and/or clinical staff (OT, PT, SLP, RD,), and Physical and Nutritional Management (PNM) team members, including credentials 5. Policies, procedures, and/or other documents related to Physical and Nutritional Management,(Policy #013 dated 1/31/2010 and #012 dated 1/31/2010) 6. Curriculum vitae (CVs) for PNMT members 7. A list of continuing education sessions or activities participated in by PNMT members since 1/2010 8. Minutes, including documentation of attendance, for the following meetings • PNMT and NMT meetings (5/2010 to 9/2010) 9. Individual PNMT reports for individuals reviewed above 10. Health Risk Screening forms (Skin Integrity, Injury, Aspiration) used to identify individuals' PNM health risk level. 11. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order. 12. Tools used to assess PNM status and needs. 13. A list of PNM assessments and updates completed in the last two (2) quarters. 14. Completed Physical Nutritional Management Plans (PNMPs) for all individuals with identified needs. 15. Tools used to monitor implementation of PNM procedures and plans. 16. A list of individuals for whom PNM monitoring tools were completed in the last quarter. 17. Tools utilized for validation of PNM monitoring. 18. For the past two quarters, any data or trend summaries used by the facility related to PNM, and/or related quality assurance/enhancements reports, including subsequent corrective action plans. 19. Nutritional management plan template and any instructions for use of template. 20. Dining Plan template. 21. Lists of individuals: (a) On modified diets/thickened liquids; (b) Whose diets have been downgraded (changed to a modified texture or consistency) during the past 12 months; (c) With BMI equal to or greater than 30; (d) With BMI equal to or less than 20; (e) Since January 1, 2010, who have had unplanned weight loss of 10% or greater over six (6) months;

	(f) During the past 12 months, have had a choking incident; (g) During the past 12 months, have had a pneumonia incident; (h) During the past 12 months, have had skin breakdown; (i) During the past 12 months, have had a fall; (j) During the past 12 months, have had a fecal impaction; (k) Are considered to be at risk of choking, falls, skin breakdown, fecal impaction, osteoporosis/osteopenia, aspiration, and pneumonia, with their corresponding risk severity (high, med, low etc.); (l) With poor oral hygiene; and (m) Who receive nutrition through non-oral methods 22. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation during the past year. 23. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials. 24. Tools and checklists used to provide competency-based training addressing: (a) Foundational skills in PNM; and (b) Individual PNM and Dining Plans. 25. Information on percent of staff with responsibilities for the provision of direct supports who have completed competency-based training on foundational skills in PNM. **Interviews with**: 1. Donna Groves, OTR (Director of Habilitation Services) 2. Six DCPs Cedar Falls 3. Four DCPs Houston Park **Observations of**: 1. Lunch and Dinner on Cedar Falls 2. Lunch and Dinner on Houston Park 3. Life Skills Training 502
	Facility Self-Assessment: The State is in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for DSSLC did not include description of Action Steps, the POI identified whether DSSLC identified as being in substantial compliance. It should be noted that the Action Steps listed by DSSLC are not fully in congruence with components of the SA that are being reviewed. Areas being reviewed by the Monitor's team are addressed in the Summary of the Monitor's assessments and findings section. DSSLC reported that they are not in compliance with multiple action steps and provisions listed under section O (Physical and Nutritional Management). These action steps include: • Speech Pathology involvement in the PSP. • PNMT that regularly meets to address change in status, clinical data, and monitoring data. • Integration of PNM issues into the PSP.

	• Consistent positioning of individuals. • Timely review of PNMPS in the occurrence of a change in status. • Congruency between strategies identified in the assessment and items included on the PNMP • Implementation of the PNMP. • Competency based training. • Comprehensive monitoring process. The monitoring team agrees with DSSLC with regards to the areas of noncompliance. The PNMT had just begun to meet but the function of their meetings as well as the extent in which they will meet had not been clearly defined. Implementation of existing plans remains sporadic and training is not consistently provided for all staff working with the individuals. DSSLC reported that they are in compliance with regards to: • all individuals being provided with dining plans. • PNMPs that specifically address positioning for individuals who receive enteral nutrition. • PNMPs being reviewed annually at the PSP. • PNMPs that contain detailed positioning instructions before, during, and after meals. • A monitoring process that provides clear direction regarding its implementation, and • An individual's PNM status is reviewed annually at the PSP and all PNMPS are updated. With regards to areas of compliance, the monitoring team found agreement with DSSLC's self assessment of the action steps listed above with the exception of issues related to monitoring. The current monitoring policy does not provide clear direction regarding professionals responsible for monitoring, the frequency of monitoring, and the acquisition of data collected through the monitoring process.
	Summary of Monitor's Assessment: **Provision O.1:** This provision was determined to be not in compliance. A Physical and Nutritional Management Team (PNMT) has been formed and there are plans to consolidate the NMT into the PNMT; however, this had not occurred as of this review. A process that outlines the responsibilities of the team as well as their scope had not yet been developed as the team is less than a month old. There was still no evidence that data is collected and the team is reviewing this data to better identify system issues or respond to recurrent issues on a regular basis. **Provision O.2:** This provision was determined to be not in compliance. DADS was in the process of developing a new risk policy and procedure that is planned to address the need to more accurately identify an individual's risk. DSSLC has developed an interim set of criteria for identifying individuals who are at an increased physical and nutritional risk. The criteria should be reviewed by DADS to ensure agreement with policy revision at the state level. Additionally, supports regarding the areas of oral care and medication administration were missing from the assessment process and were not included in the PNMP. **Provision O.3:** This provision was determined to be not in compliance. PNMPs are not regularly reviewed

	in the occurrence of a change in status and are not comprehensive due to the plans lacking information regarding oral care and medication administration. **Provision O.4:** This provision was determined to be not in compliance. Staff was observed not implementing PNMPs and displaying safe practices that minimize the risk of PNM decline. Individuals were observed poorly positioned and with safe dining strategies not implemented. Per interview, staff again was not knowledgeable of the plans and why the proposed strategies were relevant to the individuals' well being. **Provision O.5:** This provision was determined to be not in compliance. There was no process in place to ensure PNM supports for individuals who are determined to be at an increased level of risk were only provided by staff who have received the competency based training specific to the individual. **Provision O.6:** This provision was determined to be not in compliance. DSSLC has just recently increased monitoring but there was no evidence that staff or the individual were being monitored in all aspects in which the individual was determined to be at increased risk. **Provision O.7:** This provision was determined to be not in compliance. There was not a formal process in place that ensures individuals with increased PNM issues are provided with increased monitoring. At this time, this process is in its infancy and had just started to be implemented. **Provision O.8:** This provision was determined to be not in compliance. All Individuals did not receive an annual assessment that addressed the medical necessity of the tube or potential pathways to PO status. Those individuals that did receive assessments did not have clear justification as to why the tube was necessary nor did the assessments list possible pathways to oral intake.

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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	DSSCL recently combined the Nutritional Management Team and the Physical and Nutritional Management team. Based on review of minutes, the NMT has been expanded to focus more on the physical issues addressed by many individuals at DSSLC. While the team is more comprehensive, the team did not consist of a qualified SLP, OT, PT, RD, and, as needed, ancillary members (e.g., MD, PA, RNP). The team lacked a Speech Pathologist due to lack of available staff. Based on a review of PNM (PNM and NMT) Team attendance records and meeting minutes from 5/06/2010 to 9/16/2010, there was no participation by the Speech Pathologist (SLP) in any of the meetings Review of facility documentation (CVs, copy of current licenses) submitted for each PNM (NMT) Team standing member did demonstrate the following qualifications for PNM	N

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	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, 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.	(NMT) Team standing members: • In four of four licenses reviewed, a copy of the license was current. • In four of four CVs reviewed, experience in respective field was documented. Review of PNM (NMT) clinical instruction documentation submitted revealed that PNM (NMT) Team members had training and professional development in the following areas: • In five of five individual clinical instruction records reviewed, clinical instruction within the last 12 months related to physical and nutritional supports had been completed. Based on a review of 16 individual records, documentation supported that the PNM (NMT) Team met regularly but did not meet timely to address change in status, assessment, clinical data and monitoring results. Individual examples of where the PNM (NMT) Team did not meet regularly to address change in status, assessment, clinical data and monitoring results included: • Individual #342 developed aspiration pneumonia on 4/24/2010 and 7/11/2010 but there was no evidence that the PNM (NMT) met to discuss issues. There was also no evidence that the PST met to discuss the aspiration post hospitalization. This individual had over 8 pneumonias in the last 12 months but there was no comprehensive review to determine the root cause of the pneumonias. • The Monitoring team attended the PNMT/PBSC/PST meeting that focused on Individual #342. Active discussion was observed but it was evident that there had been little discussion prior to this meeting to identify root cause of the pneumonias. This determination was made by the amount of questions that staff had regarding the aspiration events, many that were not able to be answered. Issues were discussed, such as the need for an esophagram, swallow study, and data collection that should have been asked months previously before the individual had eight pneumonias over the past year. • Individual # 387 developed aspiration pneumonia on 4/6/2010 but there was no evidence that the PNM (NMT) met to discuss issues until the regularly scheduled 4/23/10 meeting. The PST did meet post hospitalization but there was no evidence of discussion of the aspiration event. • Individual #743 developed aspiration pneumonia on 4/16/2010 but there was no evidence that the PNM (NMT) met to discuss issues until the regularly scheduled 5/16/10 meeting. The PST did not meet post hospitalization to discuss the aspiration event. • Individual #309 developed aspiration pneumonia on 6/3/2010 and	

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		7/31/2010 but there was no evidence that the PNM (NMT) met to discuss issues. The PST did meet post hospitalization but there was no evidence of discussion of the aspiration event. • Individuals # 526, #255, and #90 all have BMIs greater than 40. The dietitian recommended increased exercise but there was no evidence that this recommendation was integrated into the overall plan of care. The PNMT was implemented less than one month prior to the review, so there is currently no process that clearly outlines their responsibilities. Per interview with the Habilitation Director, this was something that would need to be developed. Informally the team has met once independently and once jointly with the PBSC to address an issue with swallowing that was considered to be more behavior related. This type of collaboration represents a true interdisciplinary process. The practice of having active collaboration between teams triggers comprehensive problem solving that will assist the teams in developing a more proactive approach to treatment.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	Twelve of 18 records reviewed did not accurately identify individuals who are at an increased risk of physical and/or nutritional decline. Examples of individuals not being appropriately identified include: • Individuals #387, #743, #571, #309, #457, #135, #11, #495, #289 had aspiration pneumonia within 5 months of this review but none were listed as being at a high risk. • Individual #697 had nine falls occurring from 6/16/10 to 9/21/10 but was not listed as being at "High Risk." • Individual #350 had a BMI of 13.34 and a 14 lb weight loss from 1/10 to 5/10 but was not listed as "High Risk." Based on a review of 16 individuals, 16 of 16 Individuals are not provided with a comprehensive assessment by the PNM team 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. Currently the OT components regarding oral care and medication administration are missing from the assessment process. Additionally, the oral motor section of the assessments continued to be vague and did not provide clear objective information regarding swallow status and cannot be considered an assessment. For example: • Individual #342's OT/PT assessment (12-09) states the individual has poor oral motor skills but does not state or provide information regarding the different components of the oral motor status (i.e., lingual or labial range of motion, and anterior-posterior propulsion).	N

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		• Individual #495's OT/PT assessment (1/13/10) states the individual has poor oral motor skills but does not state or provide information regarding the different components of the oral motor status (i.e., lingual or labial range of motion, and anterior-posterior propulsion). Review of 16 records involving individuals revealed: • In 16 of the 16 records reviewed (100%), there was no documentation of PNM review/analysis of the findings, including but not limited to relevant discipline-specific assessment(s), PNMP Clinic results, PNMP, and relevant consultation(s) leading to the development of a comprehensive summary. The summary did not address: • Oral care. • Medication administration. • Mealtime strategies in a method that is clear as to why the strategies are relevant. • Rationale and Justification for Head of Bed Elevation. Head of Bed Assessment is an area that has just begun to be implemented at DSSLC. Based on a review of the two that were reviewed, DSSLC is on the right path in this area but has many assessments that have yet to be completed.. • In 16 of the 16 records reviewed, there was lack of congruency between Strategies/Interventions/Recommendations contained in the PNMP and the concerns identified in the comprehensive assessment. Congruency was not noted with regards to Oral Motor/Swallowing as it is unclear as to what the rationale or justification was for multiple dining strategies. For example: • Individual #701 should only be offered drinks at the beginning and end of meal. It is unclear as to why this intervention is needed. • Individual #565 requires all liquids to be provided by spoon but it is unclear in the assessment as to why this needed. As of this review, there was not a clear system in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with physical and nutritional risk.	
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,	All persons identified as requiring PNM supports were provided with a Physical and Nutritional Management Plan (PNMP); however, the plans are not comprehensive as they do not contain information regarding oral care and medication administration. For example:	N

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	oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	Based on a review of 27 individual PNMPs, individuals were not provided with a comprehensive PNMP. o In zero of 27 PNMPs reviewed, strategies for medication administration were included. o In zero of 27 PNMPs reviewed, strategies for oral hygiene were included. o In 27 of 27 PNMPs reviewed, individual adaptive equipment was included. o In 27 of 27 PNMPs reviewed bathing/showering positioning and instructions were included. o In zero of 27 PNMPs which indicated the need for increased head of bed elevation did not contain the degree in which the person should be elevated. There were, however, several positive practices that the Facility should ensure continue.. o In 27 of 27 PNMPs reviewed, positioning instructions for wheelchair and alternate positions instructions were included as applicable. o In 27 of 27 PNMPs reviewed, transfer instructions were included as applicable. o In 27 of 27 PNMPs reviewed, the mealtime/dining plan included intake information for mealtime and snacks o In 27 of 27 PNMPs reviewed, the mealtime/dining plan included food/fluid textures as applicable. o In 27 of 27 PNMPs reviewed, the mealtime/dining plan included behavioral concerns related to intake. In 16 of 16 records reviewed (100%) PNMPs were incorporated into the relevant sections of individual Personal Support Plans, but as mentioned previously, the PNMPs are not comprehensive as they do not contain information regarding oral care and medication administration, nor are there signs of integration across disciplines. In 16 of 16 records reviewed (100%), PNMPs were reviewed annually at the PSP meeting. In 14 of 16 records reviewed, it was unclear as to whether the PNMPs were updated as needed due to at times being a lack of assessment upon an individual's return from the hospital. Examples of when PNMPs were or were not reviewed and updated as indicated by a change in the individual's status, transition (change in setting) or as dictated by monitoring results. Individual #342 developed aspiration pneumonia on 4/24/2010 and 7/11/2010 but there was no evidence that the PNM (NMT) met to discuss issues. There was also no evidence that the PST met to discuss the aspiration post hospitalization. This individual had over 8 pneumonias in the last 12 months but there was no comprehensive review to	

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		determine the root cause of the pneumonias.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	Staff did not consistently implement interventions and recommendations outlined in the PNMP and/or Dining Plan. Twenty-six observations demonstrated that staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan which were most likely to provoke swallowing difficulties and/or increased risk of aspiration in the following areas: • In one of 11 observations, staff were following mealtime plans. • In five of six observations, staff were following wheelchair positioning instructions. • In zero of 12 observations staff were following alternate positioning instructions. • In two of two observations staff were following transfer instructions, Individuals were observed poorly positioned in bed and their recliners. Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan: • Individual # 602 was observed collapsed in on himself resulting in increased abdominal pressure. No pillow was behind his head as stated per plan • Individual # #147 was observed in a recliner with no pillow behind his head and no rolled towel beneath his feet. • No liquids were offered to Individual #308 during meal. • Individual #259 was observed in right semi-sidelying position with pillows not in the appropriate place. • Individual #639 was observed with head hanging off the wheelchair. • Individuals #571 and #595 were observed on their backs when they were scheduled to be in left semi-sidelying position. • Individual #185 was observed in left semi-sidelying position when she was scheduled to be on her back elevated. • Individual #565 was given liquids during meal straight from the cup and not by spoon as stated per PNMP. • Individual #621 was not provided with alternating liquids and solids nor was his mouth checked for food at the end of the meal Based on interviews with ten DCPs:	N

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		• In ten of ten interviews with staff, they were able to identify the location of the PNMP and/or mealtime plan • In four of ten interviews with staff , staff could describe individual-specific PNMP strategies • In five of ten interviews with staff , staff could describe the schedule for implementation of PNMP strategies • In six of ten interviews with staff , staff stated they had received individual-specific training for PNMP strategies Examples when direct support professionals were not able to describe the following PNMP indicators included: • Staff were not able to explain why Individual #779 should not have liquids until 30 minutes after meal. • Staff were not able to describe rationale for alternate positions other than to decrease risk of skin breakdown. • Staff were not able to describe why Individual #701 should not be given liquids during the course of the meal. This lack of knowledge results in individuals being placed at an increased risk due to lack of staff understanding of the rationale for implementing strategies listed in the physical and nutritional management plans. Examples of rationales include strategies to mitigate serious risk associated with poor positioning and poor intake. If staff are unaware of these, they may not observe for and report relate health concerns or ensure their actions do not contribute to these risks.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	Staff were provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff during new employee orientation. Review of the Facility's training curricula revealed that it did include adequate PNM training in the following areas: • Body mechanics • Handling techniques • Optimal alignment and support in seating systems and alternate positions • Mechanical lift transfers • Manual transfers approved by facility policy • Mealtime positioning • Food and fluid consistency • Safe presentation techniques for food and fluid • PNMPs.	N

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		Per the POI, there was no process in place to ensure PNM supports for individuals who are determined to be at an increased level of risk were only provided by staff who have received the competency based training specific to the individual. Staff who are untrained will not have the full understanding as to why strategies must be implemented as well as have the knowledge needed to identify individualized triggers associated with a change in status. Person-specific training and training in response to changes to plans of care were provided to staff who routinely work at a specific unit; however there was no process in place to provide this additional training should a unit have to utilize floating or pull staff from another area. It is essential that PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff who have successfully completed competency-based training specific to the individual. Per POI, there is no process in place at this time that provided for annual refreshers regarding physical and nutritional supports. Annual refreshers are extremely important to ensure staff maintain a high level of functional knowledge and remain current with changes in practice.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	A policy/protocol that addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted did not exist at DSSLC Based on review of the Facility's monitoring practices, a system was recently put in place to cover mealtime observations; however, this system was implemented the week prior to the review and was not able to be fully assessed at this time. As noted in the examples found in Provision O4 in which staff did not implement interventions accurately, monitoring has not yet been effective. While the system was designed to address mealtime and have multiple professionals involved, a policy or process was not fully developed that included: • Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, • Identification of monitors and their roles and responsibilities, • Monitors are re-validated on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms are correct and consistent among various individuals conducting the monitor, and • Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or	N

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		clinician. Findings of the current monitoring forms are filed with Habilitation Services and the Unit Director. Per interview with the habilitation director, the monitoring forms will soon be forwarded to QA as well. The sharing of information will further assist Habilitation Services in identifying trends across campus. The PNM team just began to meet in response to issues but does not meet regularly to respond to indicators identified by monitoring. Monitoring did not cover staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities) Examples of PNM activities that were not being monitored: • Oral care • Medication Administration • In-bed positioning All members of the PNM team did not conduct monitoring; however this was an area that was changing to include all members. Monitoring was primarily conducted by members of the PST. The frequency of the monitoring was based on the level of home risk (i.e., high risk home is a home that contains multiple high risk individuals). Listed beloware the monitoring criteria: • High Risk Apartments will have breakfast, lunch or supper monitored 50% each week This means that 50% of all meals will be monitored weekly. • Medium risk apartments will have breakfast/lunch or supper monitored 30% each week This means that 30% of all meals will be monitored weekly. • Low risk apartments will have breakfast/lunch or supper monitored once per week. Per Habilitation Director, The monitors will have a form with them every time they monitor but will only fill it out if there is an issue and once a month. This method will make it extremely difficult to determine completion of monitors. Additionally, although the frequency is high, it was a concern that only one monitoring form was completed a month unless there was an issue identified. The fear is that this will result in monitoring being done in an informal manner and will provide less data.	
O7	Commencing within six months of	A process was not in place that promotes the discussion, analysis and tracking of	N

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	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.	individual status and occurrence of health indicators associated with PNM risk. Based on the review of 16 individual records, the PNM (NMT) Team did not document progress of individual strategies on a monthly basis to ensure the efficacy of identified strategies to minimize and/or reduce PNM risk indicators for those individuals with the most complex physical and nutritional support needs. While PNMPs are reviewed at the PSP, there was not a system in place that clearly monitored the effectiveness of the plan by tracking clinical indicators such as the occurrence or absence of triggers (signs and symptoms associated with physical and nutritional decline that require staff response). Many PNMPs have these indicators listed but there was not a method that collected this data for review.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	Based on the review of eight individuals who were enterally nourished revealed these individuals did not receive an annual assessment that addressed the medical necessity of the tube and potential pathways to PO status. Examples of individuals who received enteral nutrition and did not receive an annual assessment: • Individuals #390, #326, #135, #11, #211, and #571. Eight of eight individuals with a PNMP (100%) who received enteral nutrition and/or therapeutic/pleasure feedings were provided with a PNMP. This PNMP, however, was missing the same information as listed in Provision O.3. PSPs for the individuals who received enteral nutrition did not clearly document the rationale for the continued need for enteral nutrition. Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake.	N

Recommendations:

1. Assessments must be reviewed and revised so that all aspects of physical and nutritional management are addressed. This includes assessing oral care, medication administration and positioning for these activities as well as positioning for improved GERD management and stomach emptying.
2. Individuals who receive enteral nourishment should be assessed annually to determine appropriateness of continued enteral status and the possible return to oral intake. Assessments must clearly indicate possible pathways to resume oral intake.
3. Beanbags and recliners do not provide proper support to maintain an adequate position while receiving enteral nutrition. Other positions should be investigated by DSSLC.
4. Ensure the policy and procedure for monitoring defines the process of analyzing monitoring reports formulating corrective strategies to address

specific and/or systemic areas of deficiency.

5. The monitoring system must include a mechanism to ensure that issues and concerns are appropriately identified, recorded and addressed with documentation of resolution. Each identified concern must be addressed via an action plan with evidence of completion such as staff training, submission of work order, and equipment replacement.
6. A formal process should be developed that ensures individuals who are at an increased risk receive more intensive monitoring.
7. All individuals who are determined to be at an increased risk should only be provided assistance from staff who have received competency based training specific to that individual. Identifying a sister home where all staff and cross training all staff is a possible option.
8. All developed processes should be detailed so that those reviewing an individual's history and monitoring care are easily able to ensure the loop of care was closed (onset to resolution).
9. PNMPs must be expanded to include oral care and medication administration. Strategies should not only include positioning for these activities but strategies and adaptive equipment that will assist in minimizing the individuals' risk.
10. The PNM meeting should be a collaborative meeting in which all parties bring their area of expertise to the table to investigate the etiology of such illness as pneumonia, skin breakdown, and constipation and how to prevent or minimize the reoccurrence. Change of status should result in additional meetings in an effort to provide more comprehensive problem solving and timely implementation.
11. Currently there is a PNMT and a Pneumonia Committee. In an effort to avoid conflicting information or direction and to provide a true comprehensive approach, it is recommended that the Pneumonia Committee and the PNMT becomes a single committee since they should both be focusing on the same issues.
12. DSSLC may want to consider a single PNM committee with multiple PNM teams. The PNM teams may correlate with the existing neighborhoods and focus more on being a resource to the existing PSTs. The PNM committee would continue to focus on system issues.

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: **Review of Following Documents**: 1. DSSLC Plan of Improvement, (POI) 5/17/10 2. DSSLC Supplemental Plan of Improvement (SPOI), 7/6/10 3. Records reviews for: #11, #42, #55, #129, #135, #147,#177, #185 #186, #211, #214, #220, #242, #259, #275, #289, #308, #309, #323, #326 #342, #387, #390, #457, #485, #495, #505, #565, #571, #595, #602, #616, #639, #654, #701, #741, #743, $766, #768, #776, #779 4. A list of all therapy and/or clinical staff (OT, PT, SLP, RD,), including credentials 5. Policies, procedures, and/or other documents related to Physical and Nutritional Management,(Policy #013 dated 1/31/2010 and #012 dated 1/31/2010) 6. Curriculum vitae (CVs) for PNMT members 7. Minutes, including documentation of attendance, for the following meetings • PNMT and NMT meetings (5/2010 to 9/2010) 8. Individual PNMT reports for individuals reviewed above 9. Tools used to screen and identify individuals' PNM health risk level. 10. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order. 11. Tools used to assess PNM status and needs. 12. A list of PNM assessments and updates completed in the last two (2) quarters. 13. PSPs for the individuals on the list above for whom PNM assessments and updates have been completed in the last quarter. 14. Completed Physical Nutritional Management Plans (PNMPs) for all individuals with identified needs. 15. Tools used to monitor implementation of OT/PT procedures and plans. 16. A list of individuals for whom OT/PT monitoring tools were completed in the last quarter. 17. For the past two quarters, any data or trend summaries used by the facility related to PNM, and/or related quality assurance/enhancements reports, including subsequent corrective action plans. 18. Nutritional management plan template and any instructions for use of template. 19. Dining Plan template. 20. Lists of individuals: (n) On modified diets/thickened liquids; (o) Whose diets have been downgraded (changed to a modified texture or consistency) during the past 12 months; (p) With BMI equal to or greater than 30; (q) With BMI equal to or less than 20; (r) Since January 1, 2010, who have had unplanned weight loss of 10% or greater over six (6) months; (s) During the past 12 months, have had a choking incident; (t) During the past 12 months, have had a pneumonia incident; (u) During the past 12 months, have had skin breakdown;

	(v) During the past 12 months, have had a fall; (w) During the past 12 months, have had a fecal impaction; (x) Are considered to be at risk of choking, falls, skin breakdown, fecal impaction, osteoporosis/osteopenia, aspiration, and pneumonia, with their corresponding risk severity (high, med, low etc.); (y) With poor oral hygiene; and (z) Who receive nutrition through non-oral methods 21. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation during the past year. 22. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials. 23. Tools and checklists used to provide competency-based training addressing: (c) Foundational skills in PNM; and (d) Individual PNM and Dining Plans. 24. For the prior 12 months, a list of competency-based training sessions addressing foundational skills in PNM. 25. Information on percent of staff with responsibilities for the provision of direct supports who have completed competency-based training on foundational skills in PNM. **Interviews with**: 1. Donna Groves Habilitation Director 2. Six DCPs Cedar Falls 3. Four DCPs Houston Park **Observations of**: 1. Transition times on Houston park and Cedar Falls 2. Life Skills Training on Cedar Falls
	Facility Self-Assessment: The State is in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for DSSLC did not include description of Action Steps, the POI identified whether DSSLC identified as being in substantial compliance. It should be noted that the Action Steps listed by DSSLC are not fully in congruence with components of the SA that are being reviewed. Areas being reviewed by the Monitor's team are addressed in the Summary of the Monitor's assessments and findings section. Based on review of the POI, DSSLC stated that they were in compliance with the action steps regarding individuals receiving assessments within 30 days of admission, assessments that are completed yearly, and the development of a wheelchair database. The Monitoring Team is in agreement with the above action steps being in compliance. Assessments are provided upon admission and annually as needed. The wheelchair database was comprehensive and contained all information regarding wheelchairs and wheelchair equipment.

	Action steps that were not in compliance include but are not limited to lack of a comprehensive assessment, monthly review of an individual's OT/PT status, development of a maintenance schedule for adaptive equipment, competency based training, development of a formalized monitoring process, and aggregation of data from monitoring process. The Monitoring Team found agreement with DSSLC's self assessment of the action steps regarding noncompliance. Individuals with identified issues are not consistently reviewed by OT/PT and staff working with those individuals are not consistently provided with the needed trainings.
	Summary of Monitor's Assessment: Overall, there was an approach that focuses on accommodation rather than prevention of the decline especially as it relates to the occurrence of falls. There was a lack of analysis and investigation regarding root cause of issues. This represents a reactive approach rather than a proactive approach that focuses on prevention. **Provision P.1:** This provision was determined to be not in compliance. Assessments were completed in accordance to the schedule set forth by DSSLC; however, assessments were not being consistently completed in response to a change in status. Additionally, the areas related to oral motor, oral hygiene, and medication administration were lacking in detail or were missing from the existing report. **Provision P.2:** This provision was determined to be not in compliance. Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. Also, individuals who were receiving direct services were not provided with monthly notes detailing progress with stated objectives. **Provision P.3:** This provision was determined to be not in compliance. Plans were not implemented as written and staff were not knowledgeable of the OT/PT plans. **Provision P.4:** This provision was determined to be not in compliance. A system did not exist that ensures staff responsible for positioning and transferring high risk individuals receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the	The facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience. Currently there are seven Occupational Therapists, eight Certified Occupational Therapy Assistants, five Physical Therapists and an open position for a Physical Therapy Assistant.	N

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	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.	Based on a review of CVs for each therapy clinician, the Department did document appropriate qualifications for licensed OTs, PTs, and assistants. Review of clinical instruction documentation supported that the following therapy staff did have adequate training and/or professional development: Based on review of OT/PT tracking spreadsheet, all individuals have received an OT/PT assessment and/or screening. This was validated via review of 16 records for completed OT/PT assessment/screening, including those who were recently admitted within the last 12 months. Assessment/screening indicated whether or not the individual required OT/PT supports and services for 16 of 16 records reviewed. If receiving services, direct or indirect, nine of nine individuals were provided a comprehensive OT and/or PT assessment a minimum of every 3 years, with annual interim updates (as applicable). At a minimum, the comprehensive OT/PT assessment addressed the following elements: a. Movement; b. Mobility; c. Range of motion; d. Independence The problem lies in that plans are not consistently developed to address issues: For example: • Individual #526 is above ideal body weight (IBW), but there is no exercise program in place. • Individual #221 uses a gait belt to assist with stability but there is no plan in place to minimize regression. • Individual #209 received a PT review in response to a fall occurring on 6-22-10, but there was no response to review additional falls that occurred 7/2/10 to 9/8/10. • Individual #697 received a PT review in response to a fall occurring on 6-19-10, but there was no response to review to additional falls that occurred 7/17/10 to 9/21/10. Additionally, the Oral Motor component as well as the justification of HOB elevation is	

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		lacking in detail and does not provide sufficient information to be considered an assessment. For examples, refer to Provision O2. Based on record review of 20 individuals who had experienced a change in health or physical status, 19 of 20 individuals had not received a comprehensive OT/PT assessment within 30 days or sooner as indicated to address health and/or safety. Refer to Provision O1 for examples.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	Based on review of comprehensive OT/PT assessments or updates, PNMPs and associated instructional plans, Activity Plans, Treatment plans and clinician progress notes for nine individuals receiving OT/PT services, plans were developed within 30 days of the date of the assessment/update as indicated by the assessment. Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. See Provision O.1 regarding assessments in response to a change in status and Provision P.1 for issues with plan development. Intervention plans related to positioning were based on objective findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies. Based on reviews of PNMPs and other positioning plans for nine individuals, equipment was specified for nine of nine plans reviewed. Individuals receiving direct services were not consistently reviewed by OT/PT. For example: • Individual #42 was seen by PT from 4/26/10 to 7/21/10. Other than an initial note and discharge note, there were no monthly notes defining progress with treatment and/or therapy. • Individual #177 was seen by PT from 11/08 to present time. Documentation was noted in the chart until 6/21/09 but there was no more evidence of review or discharge. • Individual #55 was seen by PT on 4/5/10 and discharged on 5/10/10. There was no evidence of a discharge note. Individuals not receiving direct serviceswere not consistently reviewed by OT/PT should there be a change in status. Refer to Provision O.1 for additional information. A concern was the failure to conduct adequate root-cause analysis of falls. This failure places individuals at risk of injury. Successful fall prevention requires a thorough clinical assessment of individuals who fall (or have a history of falls) and their	N

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		environment. After a fall, clinical staff should evaluate extrinsic factors (e.g., wet floor, loose rug), intrinsic factors (e.g., seizure disorder), and medications. A thorough assessment of gait and balance should be included as part of the assessment. Further, the appropriateness of mobility devices, such as walkers and wheelchairs, and the need for personal assistance should be reviewed regularly and re-evaluated as necessary. Such steps, which will decrease the risk of future falls, are not currently being taken. For example: • Individual #221 had four falls occurring from 6/28/10 to 9/11/10 with no evidence of assessment. • Individual #209 had seven falls occurring from 6/22/10 to 9/8/10. An initial review was conducted for the fall occurring on 6/22/10 but there was no evidence of additional review or assessment occurring with subsequent events. • Individual #697 had nine falls occurring from 6/16/10 to 9/21/10. An initial review was conducted for the fall occurring on 6/22/10 but there was no evidence of additional review or assessment occurring with subsequent events. • Individual #275 had 10 falls occurring from 6/4/10 to 9/19/10 with no evidence of assessment or review.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	Staff did not implement recommendations identified by OT/PT. Based on observations of OT/PT interventions of all PNMPs or other intervention plans were not implemented as written for nine of ten individuals reviewed in the sample. Some examples of plans not implemented as written included the following: • Individual #639 was observed with head hanging off the wheelchair. • Individuals #571 and #595 were observed on their backs when they were scheduled to be in left semi-sidelying position. • Individual #185 was observed in left semi-sidelying position when she was scheduled to be on her back elevated. Based on review of training rosters and in-service outlines, DCPs, PNMP Coordinators and therapy aides were identified as competent to implement OT/PT interventions and supports as outlined in the PNMPs and other activity plans for five of five individuals reviewed in the sample. Staff were not able to consistently verbalize rationale for interventions. Based on interviews of DCPs, staff did not consistently understand rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the OT/PT plans and /or PNMPs.	N

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		Based on interviews with ten direct support professionals: • In ten of ten interviews with staff, they were able to identify the location of PNMP and/or mealtime plan. • In four of ten interviews with staff , staff could describe individual-specific PNMP strategies. • In five of ten interviews with staff , staff could describe the schedule for implementation of PNMP strategies. • In six of ten interviews with staff , staff stated they had received individual-specific training for PNMP strategies. Examples of direct care professionals who were not able to describe the rationale for OT/PT interventions and recommendations: • DCP on 502 C was not able to describe rationale for maintaining appropriate elevation. • DCP on 512B was not able to describe why individuals used modified dining equipment. • DCP on 512C was not able to describe reasoning behind alternate positioning • DCP on 515C was not able to identify a head rest that was improperly mounted. As with physical and nutritional Supports, the failure of staff to understand the consequences associated with non implementation of interventions results in an overall environment where staff are not knowledgeable of the disorders or diseases that they are responsible for treating therefore increasing the risk to the individual.	
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	The Facility has not yet developed a system to monitor and address all the requirements of this provision, although progress has been made. Per maintenance spreadsheet and OT/PT monitors, a system exists that was designed to routinely evaluate fit, availability, function, and condition of all adaptive equipment/assistive technology. This was a positive step. A system does not exist that ensures staff responsible for positioning and transferring high risk individuals, receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff (Refer to Section O-5). A monitoring process was developed July 1, 2010 that focuses on staff implementation and competence. As of this review there is not enough data to determine effectiveness of this process. This area will be reviewed at the next compliance visit to allow for the completion of monitors and acquisition of data.	N

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	each individual; and the implementation by direct care staff of these interventions.	Per POI, there is no formal process to ensure data collection method is validated by the program's author(s). As of this review, this area is in the process of being developed and outlined. Responses to monitoring findings are not clearly documented from identification to resolution of any issues identified (Refer to O-4).	

Recommendations:

1. The current assessment format needs to be reviewed to determine if it is sufficiently comprehensive to identify the needs of the individuals at DSSLC. Special care should be given to the OT/PT relevant areas of oral care, medication administration and head of bed elevation.
2. Changes in status should trigger an automatic OT/PT assessment or review if related to area of practice (i.e.., fecal impaction, skin breakdown, falls, aspiration, pneumonia, and choking, and/or neurological event). The action taken by OT/PT should be clearly documented and followed to resolution.
3. Individuals receiving direct services by OT/PT should not only be provided with an initial and discharge note but documentation should include monthly notes that define progress on stated treatment and/or therapy objectives.
4. A process should be implanted that ensures all staff are provided with individualized competency based training prior to working with individuals who are considered to be "High Risk" or require specialized techniques and/or interventions. A possibility may be to utilize the existing neighborhood format as a way to ensure all staff in the neighborhood are trained on all individuals living in the neighborhood.
5. Formalize the monitoring process so that it clearly defines the responsibilities of all participants.
6. Ensure the policy and procedure for monitoring defines the process of analyzing monitoring reports formulating corrective strategies to address specific and/or systemic areas of deficiency.
7. The monitoring system must include a mechanism to ensure that issues and concerns are appropriately identified, recorded and addressed with documentation of resolution. Each identified concern must be addressed via an action plan with evidence of completion such as staff training.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 3. DSSLC Plan of Improvement, (POI) 5/17/10 4. DSSLC Supplemental Plan of Improvement (SPOI), 7/6/10 3. The dental records and personal support plans and addendum to personal support plans of the following individuals were reviewed: #673, #368, #572, #528, #738 4. The following policies were reviewed: Attendance problem tracking, chlorhexidine protocol, community placement, comprehensive annual exam, dental annual summary, dental emergencies, dental exams, dental infections, dental radiographs, dental recall, dental services overview, dentist, denture and partial care, npo and premed, health status risk, hygiene, informed consent, iv sedation, medications, oral care. 5. Dental Evaluation form **People Interviewed:** 1. Dr. Michael Cousins, D.D.S 2. Randy Spence, M.S. **Meeting Attended/Observations:** None
	Facility Self-Assessment: The Facility reported partial compliance with provision Q1 by ensuring that 100% of the records reviewed showed that all dental records and dental notes are in the current medical record and are accessible to the PST. The monitoring team concurs with the Facility's self assessment that dental records and notes are in the current medical records of those reviewed and that they are available for to the PST; however, the review team has determined that the records did not adequately explain dental and periodontal issues. The Facility reported noncompliance with timely emergency dental care. The review team did find the Facility in compliance with their ability to provide emergency dental services for individuals in need of emergency dental services during regular hours of operation and for after hours. The Facility reported that oral hygiene instruction is given to individuals and staff during dental clinics when problems are seen. That is inadequate to ensure good oral hygiene on an everyday basis. During the monitoring team's evaluation of dental services, it was evident that quality daily oral hygiene efforts were limited at the Facility.
	Summary of Monitor's Assessment: The Facility continued to be non-compliant with provisions of Section Q. The monitoring team concurs with the Facility's self assessment that dental records and notes are in the current medical records of those reviewed and that they are available to the PST; however, the review team

	has determined that the records did not adequately explain dental and periodontal issues. Specifically, the records did not enable the PST to understand the gravity of the individual's dental condition, risks of treatments versus not treatment, medical and behavioral complications of the dental condition and under-treatment of the condition, and alternative treatments. These issues are essential for the team to make necessary decisions on behalf of the individual. The monitoring team did find the Facility in compliance with their ability to provide emergency dental services for individuals in need of emergency dental services during regular hours of operation and for after hours. The Facility must appreciate that services provided by the dental office are only a small component of what is necessary to ensure quality dental care. Dental policies, treatments and meaningful integration of dental services into the team approach are the minimal expectations for full compliance with provisions Q1 and Q2. The monitoring team will assess efficacy of the Facilities dental program by ensuring that each individual served by the Facility benefits from appropriate dental services and in the event that standard of care practices cannot be achieved, a clear and rational explanation is well documented in the dental records and personal support plan for the individual, and that regular and robust attempts to provide needed dental services are provided.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	During the review team's assessment of dental services, the process of providing emergency dental care was discussed with the Facility's primary Dentist, Dr. Michael Cousins, DDS. Although there is a specific policy and procedure delineating dental emergencies, the policy was limited to who to contact in the event of an emergency, important assessment and follow-up instructions were not discussed. When asked about specific dental emergencies, Dr. Cousin, who is new to the Facility, was aware of only one emergency case in which the individual was initially triaged to the local hospital and then followed-up upon by the Facility's Dentist the following morning. The Facility did have an adequate emergency process in place that directed all dental emergencies to be immediately triaged by the Facility's Dentist or covering contract dentist during business hours and to immediately triage the individual to the local emergency department for initial assessment and initial treatment of pain and possible infection, with prompt follow-up with the Facility's Dentist on the next business day. The process replicated community standard of care practice for many people, with and without disabilities, who reside within the community. With regards to routine dental services, the facility ensured that individuals were seen at the dental clinic as scheduled; however, there was a significant backlog of individuals awaiting specific treatments, such as fillings, root canals, deep cleaning and prosthetics. The Facility was ill equipped to provide appropriate routine dental services secondary to	N

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		lack of understanding on how to utilize and apply non-sedating forms of physical support and lack of resources to manage individuals who require either intravenous (i.v.) or general anesthesia. At the time of the review, the monitoring team was unable to obtain a firm number of individuals who were awaiting definitive treatment for their dental issues; however, Dr. Cousins informed the monitoring team that the number is "high." Dr. Cousins explained to the monitoring team the current tiered strategy in providing services. The minority of individuals served by the Facility are those that can tolerate dental procedures without the use of pre-treatment or other forms of sedation. These individuals were provided services at the time service is scheduled or otherwise required. Another group consists of individuals who require minimal pre-treatment anxiolysis. This group was also addressed at the time of a scheduled appointment. For those individuals who experience more severe behavioral challenges, the individuals were sent to the dental clinic, and when possible, an oral inspection was conducted, sometimes at a distance. Depending on the findings of the oral inspection the individual was either scheduled for i.v or general anesthesia or was rescheduled and reassessed at the clinic at a later time. Following discussion with Dr. Cousins, it was evident that a significant number of individuals that require active dental treatment were not provided treatment timely, because of lack of resources such as limited support staff at the Dental Office, limited understanding on how to provide dental services with minimal physical supports, limited dental referral services to assist in performing complex dental procedures and limited ability to provide i.v and general sedation to individual who require sedation. Specific to the Facility's personal resource issue, the Dental Office had only one dental assistant who was responsible for assisting with dental procedure and providing clerical support, which included obtaining consents for all persons who require dental services at the Facility. When this person was not available, there was limited support for the office; hence, scheduling and obtaining consents fell behind. There was only one technician to support the dentist at the Facility. It is important to note that efficient DD dental clinics rely on at least two technicians to support the Dentist and Hygienist to perform dental procedures; in a facility of this size, this is also required in order to have adequate support for oral hygiene monitoring and to have clerical support to maintain records and obtain consents.	
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	Dental records were not sufficient to provide meaningful and comprehensive documentation of the individual's dental needs. The documentation practice was limited and did not adequately delineate the dental needs of individuals so that members of the interdisciplinary team can appreciate the severity of dental issues and their ramification on health and habilitation. Importantly, dental services were not routinely addressed by	N

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	procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	the personal support team or reflected in the personal support plan in a meaningful way. Usually only brief mention of recommendations were commented upon in the PSP but ramifications of oral and dental pathology where not documented, especially for serious cases. Upon cursory review of clinical records at the living area, instances of significant dental issues were not clearly and rationally documented in the personal support plan or addendums to the personal support plans. Given professional resource shortages, the Facility must develop an efficient mechanism to enable the integration of dental services into the Facility's integrated team approach to health care. Since having the dentist attend the annual review of each individual at the Facility is not possible with current staffing, enhancement of documentation practices must be ensured by the Facility so that the Dentist and the rest of the PST have the information needed to do appropriate integrated planning of all services. At the time of the review, the Facility had yet to initiate a dental desensitization program, per psychology services. Psychology services were, however, in process of developing a strategy to address desensitization. Current policies specific to dental services that refer to pre-treatment medications and other forms of sedation were completely inadequate and noted to be limited in detail and ambiguous. The Facility, in collaboration with Central Office, must re-evaluate their policies on sedation. During the monitoring team's evaluation of dental services, it was evident that quality daily oral hygiene efforts were limited at the Facility. As an exampleIndividual # 673 had undergone extensive deep cleaning, under sedation upon re-evaluation within one week of the procedure, the individual had extensive plaque buildup, which could only occur if the individual was not provided with adequate daily oral hygiene. There was evidence, including interview with the Dentist and observations of people finishing lunch at various homes that indicated oral hygiene as provided by direct care staff was inadequate, and did not meet the needs of individuals served. This is a barrier to care and an indication that the Facilities dental program is inadequate at the primary level of care and support of individuals served.	

Recommendations:

1. The Facility must immediately develop and implement meaningful behavior programs to minimize the need for pre-treatment and other sedation for individuals served to permit completion of dental procedures.
2. It is imperative that provision of oral hygiene at the living areas be immediately improved and that status of oral hygiene be monitored, tracked, and trended to identify areas that continue to need improvement.

3. Dental records must be enhanced to meet current, generally accepted practices in dentistry for people with intellectual disabilities.
4. Enhancement of documentation practices must be ensured by the Facility so that the Dentist and the rest of the PST have the information needed to do appropriate integrated planning of all services.
5. Dental documentation must be improved and include issues such as risk/benefits of treatment versus no treatment, alternative treatments, clear description of the clinical issues and potential medical and behavioral manifestation of the treatment.
6. The Facility must review all dental policies, especially those related to sedation and pre-treatment medications.
7. The Facility should review staffing issues and consider the addition of at least one full time dental assistant. The Facility should also review the current dental contract positions and consider the cost and benefit of converting the contract positions to a second full time dentist.
8. The Facility must explore training possibilities to enhance the dental clinicians' understanding and comfort with non-medication forms of physical and other support.
9. It is essential that the delivery of actual dental care be improved upon by allocating necessary resources to ensure individuals served receive necessary dental treatment as necessary.

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: **Review of Following Documents**: 1. DSSLC Plan of Improvement, (POI) 5/17/10 2. DSSLC Supplemental Plan of Improvement (SPOI), 7/6/10 3. Record reviews of Individuals: #1, #129, #211, #289, #309, #326, #342,#387, #390, #392, #457, #478, #495, #571, #670, #731, #741, #743, and #776 4. Policies, procedures and/or other documents addressing the provision of speech and/or communication services and supports (policy 016) 5. A list of people with Alternative and Augmentative Communication (AAC) devices 6. AAC evaluation and Speech Language assessment template. 7. Five (5) most current AAC and SLP assessments conducted by each therapist, and corresponding PSPs. 8. Monitoring tools template for ACC and SLP programs. 9. Communication dictionaries for individuals identified as having decreased communication. 10. AAC-related spreadsheets. 11. List of individuals receiving direct speech services, and focus of intervention. **Interviews with**: 1. Joy Sibley CCC-SLP Director of Communication Therapy 2. Donna Groves OTR Director of Habilitation Services 3. Life Skills Instructors (502) 4. 4 DCPS (Cedar Falls) and 3 DCPS (Houston Park) **Observations of**: 1. Life skills Training 502 and 512 2. Transition times Cedar Falls and Houston Park 3. Common areas 515d and 515c
	Facility Self-Assessment: The State is in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for DSSLC did not include description of Action Steps, the POI identified whether DSSLC identified as being in substantial compliance. It should be noted that the Action Steps listed by DSSLC are not fully in congruence with components of the SA that are being reviewed. Areas being reviewed by the Monitor's team are addressed in the Summary of the Monitor's assessments and findings section. Based on review of the POI, DSSLC stated that they were in compliance with R.1 action steps regarding the presence and use of a system approved evaluation tool to identify individuals for communication needs. The Monitoring Team found agreement with DSSLC's determination of compliance with regards to the use of a state approved speech evaluation and the comprehensiveness of the tool.

	All other action steps were stated to be not in compliance. These include but are not limited to: presence of a localized Speech process, availability of speech therapy, the providing of speech assessments to those with identified needs, competency based training, monitoring of programs to ensure implementation and accuracy of implementation. The Monitoring Team is in agreement with DSSLC's determination of noncompliance. DSSLC has accomplished very little regarding this area. Individuals in need of assessment remain in need of assessments. Individuals who are nonverbal and may benefit from an AAC device are not being provided with that opportunity thus limiting their ability to be an active participant in the environment.
	Summary of Monitor's Assessment: **Provision R.1:** This provision was determined to be not in compliance. DSSLC has 3.5 positions open but these have not been filled as of this review. Individuals who are need of AAC were still not receiving adequate supports. **Provision R.2:** This provision was determined to be not in compliance. Individuals identified as having decreased communication have not consistently been provided with the needed assessments. Programs in place to assist some individuals are not being consistently implemented. **Provision R.3:** This provision was determined to be not in compliance. AAC devices are not consistently portable and functional in a variety of settings. DCPs interviewed were not knowledgeable of the communication programs. **Provision R.4:** This provision was determined to be not in compliance. DSSLC was in the process of developing a monitoring process to address the presence and working condition of the AAC devices but were not monitoring whether or not the device was effective and or meaningful to the individual. Little to no progress has been noted with regards to meeting compliance in the four provisions listed above. Effort focusing on the use of object cards and integration of these cards into life skills training has begun on the Cedar Fall's apartment 502 but no noticeable improvement was yet to be observed. Even in areas where the presence of object cards was noted, there was little to no use of the cards.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized	The facility did not provide an adequate number of speech language pathologists or other professionals (i.e. Assistive Technology (AT) specialists) with specialized training or experience so that individuals with identified Speech issues receive the necessary services. There was only one speech therapist available at DSSLC and the therapist was only available part time. One therapist left and another was on maternity leave until November. A new therapist is scheduled to start October 1, 2010, and was in orientation training during the compliance visit.	N

#	Provision	Assessment of Status	Compliance
	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.	With the current numbers, it will be extremely difficult for DSSLC to begin to address the issues identified in this section. 14 out of 16 records reviewed indicated individuals with identified language difficulties were not receiving active Speech Treatment or participating in a Speech program. Examples of Individuals with identified Speech or language difficulties not receiving services: • Individuals #211, #571, #387, and #342 have decreased expressive and receptive speech but there was no evidence of programs in place to address this issue. • Individual #390 has decreased communication. The QMRP stated 12/7/09 that another assessment would be requested since the last Speech Assessment was conducted in 1992. There was no evidence that this was provided. Communicative aids and speech generated devices (simple and complex) are not provided to individuals based on need. Not all individuals in need of AAC were receiving AAC. Additionally, due to the low SLP numbers, SLPs were unable to actively participate in all facets of care in which communication was relevant. Based on a review of five individuals who were identified with moderate to severe expressive or receptive language, none were receiving supports designed to improve or augment existing language. Examples include: • Individuals #11, #670, #478, #326, and #392 were not observed utilizing their AAC or environmental control devices during life skills training or upon returning to their apartments.	
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	Through interview with the Director of Communication Therapies and based on review of individuals observed to be nonverbal and/or with a limited form of expressive language, it was noted that there were numerous individuals in need of AAC who were not consistently identified as being in need of AAC. The majority of the individuals living at DSSLC have not been provided with comprehensive Speech or AAC assessments. Per interview with the Communication Therapy Director, DSSLC has developed a 5 year plan that will result in all individuals receiving an assessment. As of this review, 100 individuals have received an assessment by the Speech Language Pathologist. This number has not changed since the baseline review.	N

#	Provision	Assessment of Status	Compliance
	interventions.	Per interview with the Habilitation Director and Director of Communication Therapy, there was no clear policy or process that defines the schedule or criteria regarding whether an individual receives a speech update or full assessment. In addition, there was no policy in place that defines the frequency in which such assessments would be provided. Fourteen of 15 records reviewed indicated individuals identified with severe expressive/receptive language did not have AAC investigated and assessed. Examples of individuals diagnosed with severe language difficulties where AAC was not assessed or investigated include: • Individual #342 was identified as utilizing only vocalizations. There was no evidence that AAC was investigated as a possible supplement to verbal language. • Individual #495's communication assessment in 2001 stated that there was a need for additional AAC assessment; however, there was no indication that this occurred. Additionally, there were individuals living at DSSLC who had not had assessments in excess of 15 years. For example: • Individual #390 is nonverbal and had not had an assessment since 1992. • Individual #731 has decreased receptive and expressive language but had not had an assessment since 1999. Upon review, the new assessments are much more comprehensive and appear to address the concerns listed below but have not been implemented to a point that compliance can be determined. In 3 of the 15 records reviewed, the Communication Assessment addressed the generally required areas of: • Verbal and nonverbal skills, • Expansion of current abilities, • Development of new skills. and • Whether the individual requires direct or indirect Speech Language services. Examples of the communication assessment not addressing all areas: • Individuals # 741, #457, #390, and #309 did not have assessments that clearly identified strengths associated with the individual current communicative status.	

#	Provision	Assessment of Status	Compliance
		For persons receiving behavioral supports or interventions, the Facility has a process designed to identify who would benefit from AAC or speech assistance. Currently the SLP attends all Positive Behavior Support Committee meetings and provides consultations to those who are identified as having speech or language issues that may be contributing to the target behavior. Goals written by the Speech Pathologist (SLP) are not consistently followed and data acquired regarding the goal are not analyzed by the SLP. Although the goals are written by the SLP, due to their limited availability, the SLP is unable to follow an individual's progress resulting in goals that may become stagnant over time due to lack of progress or meaningfulness to the individual. Communication dictionaries were developed by the QMRP with input from the team. This dictionary is to be utilized by staff in an effort to improve interaction and understanding of those individuals who are nonverbal. Discussion with ten DCPs at Cedar falls and Houston Park indicated that staff was not knowledgeable of this dictionary or its contents.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	Results from the speech assessment were only mentioned in the PSP. Rationales and descriptions of communication interventions regarding use and benefit were not clearly integrated into the PSP. Strategies may be listed but these strategies were not consistently integrated into Action Plans or activities of daily living. Lack of integration results in a lack of generalization of objectives. Zero of the 16 records reviewed had a clear rationale and description of communication interventions integrated into the PSP. Examples of PSPs in which communication was not adequately integrated: • Individual # 495's PSP states that he is nonverbal but did not provide information on how to expand or integrate strategies into the daily schedule • Individual #571's PSP states to use special instructions but did not state what these instructions were and how they would be implemented across all settings. • Individual # 741's PSP just states that no formal communication is needed at this time. The individual was nonverbal and had limited communication skills, yet the PSP did not integrate communication strategies into the individual's goals. Five of five observations of individuals did not have communication strategies integrated	N

#	Provision	Assessment of Status	Compliance
		into the daily schedule. Examples of Communication interventions not being integrated into the daily schedule • Individuals #11, #670, #478, #326, and #392 were not observed utilizing their AAC or environmental control devices during life skills training or upon returning to their apartments. Zero of five records reviewed clearly indicated how the individual communication programs were functional and meaningful to the individual and how it improved his/her daily living. DCPs and Life Skills Instructors interviewed were not knowledgeable of the communication programs as evidenced by: • In four of ten interviews, professionals were not able to locate adaptive equipment. • In ten of ten interviews with staff , staff could not describe individual-specific communication strategies. • In seven of ten interviews with staff, staff could not describe the schedule for implementation of communication strategies. • In four of ten interviews with staff, staff stated they had not received individual-specific training for communication strategies. Instances in which individuals' communication plans were not able to be described by staff included: • Discussion with ten DCPs at Cedar falls and Houston Park indicated that staff were not knowledgeable of this dictionary or its contents. • A Life Skills Instructor stated that environmental control devices were utilized to kill time and keep individuals occupied. General AAC devices are not readily available in common areas. There are many AAC devices at the apartments not in working order. For example: • Common area AAC devices on 515C were ether not working or turned off. • Common area AAC devices on 522B and 522A were in poor condition and not working properly. Per the Communication Therapy director, increasing the presence of object boards and cards will be a focus over the next six months. Four observations demonstrated that staff did not utilize common area AAC devices.	

#	Provision	Assessment of Status	Compliance
		DSSLC has training and development records that are and will be completed by the Speech Pathologist. This practice should help promote more functional and relevant goals and objectives for the individuals. Per interview with the Director of Communication Therapy, data will be taken only by the life skills director and not from other DCPs. This process was being implemented to increase accuracy of documentation. The issue with this process is that although the devices will be checked off during other times of the day in addition to the formal training, no data will be taken during other times of the day thus making it extremely difficult to assess generalization of acquired skills.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	DSSLC had a monitoring form that tracked the presence and working condition of the AAC equipment; however, implementation and effectiveness were not evident. Monitoring should cover all areas in which the use of the device is applicable (which should be all the time). Effectiveness of the device may only be determined by a professional with expertise in that related area; therefore, the implementation of the plans should be followed by the Speech Pathologist. Additionally, the results of the monitors are not collected and utilized to drive future speech interventions. Per observation and review, the current monitoring process was not effective in maintaining the proper functioning or implementation of AAC devices, as demonstrated by the examples in Provision R3. Per interview with Communication Therapy director, devices are often misplaced or lost resulting in devices often having to be replaced. This results in a delay of providing treatment and devices to others. Validation checks are not built into the monitoring process and conducted by the plan's author to ensure correct implementation or interrater reliability between monitors.	N

Recommendations:

1. Continue to expand the presence of common area AAC as well as the implementation of such devices. There are multiple opportunities for Communication training, especially during times of transition and day programming. Because of this, these areas should be integrated into the overall level of care.
2. Once direct treatment is concluded, expand integration of communication strategies and devices into the individual's daily life. Training of augmentative communication must occur throughout the day and not only during structured treatment sessions.
3. SLPs should participate more actively in the annual PSP process. Individuals who have communication needs are not being represented by those

who have the most expertise in the area.

4. Continue to work closely with Psychology so that individuals who have behavioral issues related to lack of communication are provided with collaborative services from Psychology and Speech Therapy.
5. Develop a monitoring system that will ensure not only the presence of the device but appropriate implementation and effectiveness of the device and/or program.
6. Ensure Training and Development Records are functional and are directly linked to the acquisition of language and/or speech.
7. Expand training so that the SLP is directly involved in the training during new employee orientation as well as with the life skills instructors.
8. DSSLC may want to consider allocating the funds set aside for additional Speech Therapists and using the money to assign Speech assistants to assist with the monitoring and/or implementation of the Speech programs. It is a concern that with the current number of staff, it will be extremely difficult to make the needed gains in this section.

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. Denton Plan of Improvement (POI) 5/17/10 2. Denton Supplemental Plan of Improvement (SPOI) 7/6/10 3. Documents that were reviewed included the annual PSP, PSP updates, SPOs, PBSPs, treatment data, teaching data, progress notes, psychology and psychiatry evaluations, physician's notes, psychotropic drug reviews, consents and approvals for restrictive interventions, safety and risk assessments, and behavioral and functional assessments. All documents were reviewed in the context of the POI and Supplemental POI and included the following individuals: #14, #20, #45, #78, #79, #94, #110, #123, #127, #134, #172, #182, #222, #229, #269, #297, #306, #334, #335, #337, #349, #381, #406, #449, #451, #482, #483, #488, #490, #537, #540, #578, #590, #606, #619, #781 4. Counseling/psychotherapy plans for individuals #79, #110, #483, #781 **People Interviewed:** 1. Randy Spence, MS – Director of Behavior Services 2. Jim LeVell, PhD, BCBA-D 3. Lori Powell – Settlement Agreement Coordinator 4. Frank Padia – Director of Program Coordination 5. Shillonda Perkin – QMRP Educator 6. Rosalyn Montgomery – QMRP (Cedar Falls) 7. Sheila Carpenter – Director of Life Skills Development 8. Linda Ford - Director Active Treatment 9. Barbara Herndon – Director of Vocational Services 10. Luz Mendoza – Director of Recreation 11. Joy Sibley – Director of Communication Therapy 12. Elaine Davis – CTD Director 13. Danielle Jones – Program Supervisor 14. Karen Slaughter – Building Coordinator (512C) 15. Ruth Starrett – Speech Tech 16. Renee Dotson – Speech Tech **Meetings Attended/Observations:** 1. Positive Behavior Support Committee 2. Positive Behavior Support Committee/Physical Nutritional Management Committee 3. Observations were conducted in the primary workshop, as well as 502, 503, 512, 522, 523, 524 and 525
	Facility Self-Assessment:

	The Facility reported that it is not yet in compliance with any provision of this Section. Based upon observations and record reviews, it would appear that the Facility Self-Assessment was accurate. Although no provisions of this section were in substantial compliance, some progress was evident. • Training on a new PSP procedure (Supporting Visions) had been implemented, but only several days prior to the compliance visit; insufficient time had passed to determine any effect upon compliance with the Settlement Agreement. • Efforts were underway at State Office to develop a replacement for the PALS assessment and facilitate the task analysis process. Both these efforts may enhance compliance with the Settlement Agreement, but additional compliance visits will be necessary to determine the effect. • The quantity of community access opportunities was substantially increased and a limited number of community employment opportunities were under development. The Settlement Agreement addresses not only the quantity of community opportunities, but the provision of training in the community as well. Staff acknowledged ongoing challenges to the delivery of training in the community, such as the ability of the staff to be effective teachers, maintaining a consistent level of active treatment, and ensuring that staff implemented the skill acquisition programs for which they were responsible.
	Summary of Monitor's Assessment: **For Provision S.1:** This provision was determined to be not in compliance. The Facility reported that minimal changes had been implemented in regard to this Provision. Observations and record reviews reflected substantial limitations in formal assessment and skill acquisition plans. **For Provision S.2:** This provision was determined to be not in compliance. An annual assessment process did typically take place, but the process lacked rigorous and meaningful assessment. **For Provision S.3:** This provision was determined to be not in compliance. The Facility had made progress in providing community access and opportunities, but this process had not been sufficiently standardized or monitored to allow for a determination of substantial compliance.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized	The review process consisted of a review of the records for 36 individuals, as well as observations of program implementation. Three of those individuals were selected by the Facility as being "best work" examples from the revised PSP process. Only three records were identified as "best work" examples as the revised PSP process has been in effect for only a brief amount of time. Due to the goal of strengthening a skill or behavior, effective skill acquisition	N

#	Provision	Assessment of Status	Compliance
	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.	development and implementation requires many of the same basic components as behavior support plans: Comprehensive assessment of skills and individual resources, the use of formal training methods that include adequate opportunities for training and high levels of reinforcement, an evidence-based and empirical approach to teaching, valid and reliable data collection, and a sound strategy for assessing progress. When one or more of these components are lacking, the ability to provide adequate habilitation services is severely compromised. At the time of the baseline visit, habilitative services at DSSLC were found to reflect substantial limitations in several areas, such as skill acquisition programs that lacked basic components, included training methods that were too vague and provided too few opportunities for learning and reinforcement. Based upon reports from staff, record reviews and observations during the current compliance visit, conditions at DSSLC had changed minimally since the baseline visit. Comprehensive assessment of skills and abilities reflected substantial limitations at DSSLC. • Only nine percent of psychological assessments included a formal assessment of adaptive behavior completed within one year of the report and none included an interpretation of adaptive behavior assessment results or specific strengths and limitations. • Assessments of behavior and function revealed no specific statements regarding hypotheses of the function of the behavior, were at least a year old in 53% of records sampled, and consisted only of screenings rather than full assessments in 62% of records sampled. • All records sampled revealed the continued use of the PALS assessment tool. The PALS had been identified as an inadequate assessment during the baseline visit and was also indicated as substantially lacking during the most recent CMS survey. • No records reviewed reflected the use of a formal task analysis or preference assessment. Substantial limitations were also encountered in the components of skill acquisition plans. In 35 of 36 records reviewed, target behaviors or skills lacked operational definitions, teaching procedures lacked sufficient specificity to ensure consistent implementation, training sessions were too infrequent or the number of trials too low for the development of skills, reinforcement was not specified or consisted of vague statements about verbal praise, and no strategy for generalization was identified. Examples of these limitations are provided below.	

#	Provision	Assessment of Status	Compliance
		Individual #123 had a skill acquisition program to learn to buckle the seatbelt in the van used for transportation. The plan contained the following limitations: • The target of buckling the seat belt was not defined. It is implied that the individual was to latch the seatbelt in front as in normal use, but this was never specifically stated. • The method of the program did not include any instructions for prompting or assistance if the individual did not complete the task following the first verbal prompt. • Reinforcement was indicated to be verbal praise, but it was not indicated whether reinforcement was to be provided after each step or at the end of the task. There were no findings in assessments or PSP to support the use of verbal praise was reinforcing for this individual. • The program defined success as successful completion of three out of five attempts, but did not indicate if there was to be five trials during each daily session or one trial per day for five days. • Data recording was described as scoring a plus if the individual completed three out of five trials and a minus if fewer than three out of five trials were completed. Using such a system prevented determining if the subject was achieving some progress, such as increasing from one out of five trials to two out of five trials. Individual #45 had a vocational training program to become more independent in her work skills. The training instructions consisted of this statement: "*During work hours (#45) will be requested not to be concerned in any way with her peers situations or issues and only be concerned with situations or concerns regarding her. She will try to boss, verbally correct, tattle or any other thing or way she can be concerned with their situations or issues. If she remains only concerned with situations or issues regarding her and not become concerned in her peers situations or issues without requiring any kind of prompts place a + in the data slot and give verbal praise. If she does become concerned in any way with situations or issues with her peers and not regarding to only her or if she requires any kind of prompting not to do so place a - in the data slot and continue to train throughout the work session."* This program reflected the following limitations. • The objective of the program was not measurable. • No operational definitions of the target skills were provided. • No specific duration for training sessions was indicated. In practice, the potential exists for four 10 minute sessions on Monday to be compared with four sessions on Friday consisting of one hour each. Valid comparisons require training sessions of equal length. Individual #182 had a money management program with an objective that stated, "*With*	

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		1, verbal prompt (#182) will read the price tag on a CD 80% of data trails for 3 consecutive months by 07/05/11." The training instructions for the program consisted of the following statement, "*When (#182) is at the store and looking at CD. Give him 1 verbal prompt to read the price tag on the CD. After he reads the price ask him if he as enough money to make the purchase. If successful, Place a "+" in box, If unsuccessful, Place a "-" in the box.*" This program reflected the following limitations. • The objective of the program required the individual to read the price tag, but the training instructions contained additional requirements. • Criteria for reinforcement in the training instructions did not indicate if the price tag was to be read to self or aloud and allowed for reinforcement if the individual was incorrect if he stated that he possessed sufficient money to purchase the CD. • The program provided for one learning trial per week. It was not indicated if this was sufficient to allow for acquisition of the skill within the expected time frame. • The training instructions did not include any actual process for increasing skill. Reviews of the records for 36 individuals, as well as observations of those and other individuals in a variety of settings reflected an inability to provide reasonable levels of individualized engagement. In several settings, there was a pervasive lack of engagement. • Staff in the Language Enrichment classrooms did not indicate understanding of reinforcement procedures and were unable to demonstrate how to use some individual work stations. One purpose of activities in the classroom was described as, "to keep them busy." • Individuals living at 512D were observed to engage in loud bruxism without intervention or redirection from staff. • Individuals in multiple residences and classrooms were observed to engage in rocking or other rhythmic behaviors without redirection or intervention. • Individuals who had received training with communications devices often were not provided with those devices. In some locations, the staff were observed to be successful in providing active treatment and effective intervention. This was most noted in the classrooms located at residence 524. Observations revealed that staff were actively engaged with all individuals, were knowledgeable about the skill acquisition programs, and were actively recording data. Danielle Jones, the Program Supervisor described in detail how staff in the classrooms had informally used attention and praise to elicit increasing levels of interactions from Individual #412.	
S2	Within two years of the Effective	Record reviews revealed that for 36 of 36 individuals, documentation of annual	N

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	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.	assessments were available in the record. As reported in Provision K, as well as in Provision S1, substantial limitations were found in the assessment reports and procedures. In general, attempts by the Facility to assess individual strengths, limitations, barriers, etc. typically involved anecdotal statements, narrative reports, and generic rating scales. While these approaches could produce correct findings, research has indicated that such strategies are often inaccurate and misleading. To ensure that findings are valid, it is necessary to conduct objective assessments that can corroborate the subjective or informal attempts at assessment. Record reviews at DSSLC did not reveal formal and objective attempts to corroborate informal and subjective assessments.	
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:	DSSLC did not yet use information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition.	N
	(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	Observations revealed the following issues involving skill acquisition program implementation. a. Training programs for individuals living at the Facility often lacked structure, being presented without clear steps or trials. b. Consequences that were intended as reinforcement following successful attempts during training typically involved verbal praise. Verbal praise can serve as reinforcement, but it was not clear from observation that verbal praise was limited only to those individuals for whom it was reinforcing. As noted in Section K, there were few examples of comprehensive functional assessment. Furthermore, there were no examples of assessments of preferences to identify consequences that might serve as reinforcement. c. Although staff often offered general prompts in order to elicit cooperation in non-training circumstances, no examples of formal and consistent prompting or opportunity for practice was observed. d. Data for skill acquisition programs were not graphed; graphing would assist in identification of progress and timely response to lack of progress. e. It was not clear from available progress notes that individuals had strengthened existing behaviors or developed new skills because of skill acquisition programs.	N
	(b) Include to the degree	At the time of the compliance visit, DSSLC had increased the total number of community	N

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	practicable training opportunities in community settings.	activities from 213 in March, 2010 to 313 in August. In June and July of 2010, the number of community activities had actually been higher, with 357 outings in June and 374 in July. It was evident that substantial progress had been made in increasing community opportunities. Some progress had also been demonstrated in community employment for individuals living at DSSLC. Although not finalized at the time of the compliance visit, efforts had been initiated with the local Wal-Mart to employ two individuals. Although any increase in community opportunity and employment is welcome, in consideration of the number of individuals currently residing at DSSLC, the potential addition of two employment positions was rather modest. This provision of the Settlement Agreement addresses not only the quantity of community opportunities, but the provision of training in the community as well. In discussions with staff it was indicated that attempts were made to offer training in diet, communication, behavior, money management and other skills during community outings. Staff also acknowledged substantial challenges to the delivery of training in the community. These challenges involved training the staff to be effective teachers, maintaining a consistent level of active treatment, and ensuring that staff implemented the skill acquisition programs for which they were responsible. It was also noted that that the same issues that limited effective skill acquisition programming at the Facility, as discussed in Provisions S1 and K, affected the quality of training in the community.	

Recommendations:

1. Staff members tasked with the development of skill enhancement programs at DSSLC do not possess an adequate understanding of applied behavior analysis. The facility should develop and implement a competency-based training curriculum emphasizing applied behavior analysisand techniques for the development of skill acquisition and enhancement programs. In addition, the facility should implement routine monitoring of skill acquisition programs to ensure essential components are present, as well as the implementation of those programs to ensure they are implemented accurately.
2. The ability to use applied behavior analysis in teaching new skills is important, as indicated in the first recommendation above. Other skills, such as relationship building, making learning enjoyable, providing choice and encouraging motivation, are also critical to effective teaching. The staff members at DSSLC who are responsible for teaching lacked many of these skills. The facility should develop and implement a competency-based training curriculum for these employees emphasizing the skills necessary in the implementation of training programs.
3. The Facility should continue to identify and expand opportunities for learning in community settings.
4. Effective teaching requires sufficient resources and personnel. DSSLC had added personnel in some settings, but it is not clear that these additional staff were being used to enhance teaching. It is recommended that DSSLC review the availability and utilization of resources and personnel and implement changes that ensure effective teaching.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Denton State Supported Living Center (DSSLC) Plan of Improvement (POI), dated 5/17/10 2. DSSLC Supplemental POI, dated 7/6/10 3. DSSLC Report for Monitors, dated 9/27/10 4. Since January 1, 2010, a list of all individuals who have been referred for community placement by his or her PST, including name, date of recommendation and current residential status. 5. Since January 1, 2010, a list of all individuals who have requested community placement, but have not been referred for placement. 6. Since January 1, 2010, a list of all individuals who have been transferred to community settings, excluding those whose discharge may be classified as an "alternate discharge." 7. Since January 1, 2010, a list of all individuals who have been discharged pursuant to an alternative discharge. 8. A current list of all alleged offenders committed to the facility following court-ordered evaluations. 9. Since July 1, 2009, list of all individuals who have been assessed for placement date of assessment, and resulting recommendation(s). 10. For the last six (6) months, a list of all trainings/educational opportunities provided to individuals, families and LARs to enable them to make informed choices. 11. Since January 1, 2010, a list of all individuals who have had a Community Living Discharge Plan developed. 12. DSSLC Provider Fair flyer for the event held on 9/10/10, including attendance sheets 13. DSSLC Orientation/Pre-service Training curriculum 14. Personal Support Plans (PSPs) for 12 individuals: Individuals #56, #120, #126, #290, #291, #381, #406, #489, #585, #590, #632, #795 15. MRA Community Living Options Process (CLOIP) Worksheets for 12 individuals: Individuals #56, #120, #126, #290, #291, #381, #406, #489, #585, #590, #632, #795 16. Completed Post Move Monitoring (PMM) checklists for 15 individuals: Individuals #16, #343, #348, #400, #422, #437, #455, #465, #470, #620, #688, #716, #717, #719, #796 17. Community Living Discharge Plans (CLDP) for eight individuals: Individuals #343, #348, #381, #516, #620, #688, #716, #717 18. Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for seven individuals: Individuals #343, #348, #381, #620, #688, #716, #717 19. Supporting Visions training curriculum 20. Six sets of Self-Advocacy minutes 21. DSSLC QMRP Manual **People Interviewed:** 1. Andy Maher, Director of Consumer and Family Relations (CFR)

	2. Frank Padia, Director of Program Coordination 3. Shillonda Perkins, QMRP Educator 4. Lauri Cross, Post-Move Monitor 5. Donnie Wilson, DADS Continuity of Services Coordinator 6. Individual #562 7. Individual #381 8. Individual # 470 9. LAR for 2 individuals: Individuals #562, #705 **Meetings Attended/Observations:** 1. PSPs for 2 individuals: Individuals #562, #705 2. Post Move-Monitoring Visits for Individual # 470 3. Supporting Visions PSP Training
	Facility Self-Assessment: The Monitoring team reviewed the DSSLC POI and Supplemental POI. The POI indicated that the DADS State Office Policy Unit would be responsible for the development of statewide policies, procedures and practices that will provide guidance to the facilities in these requirements of the SA. Overall, the Facility indicated it was not in full compliance with any of the provisions of Section T. The Facility did indicate that it believed it was in compliance in several sub-sections, including certain aspects of Community Living Discharge Plans. These key indicators included, under T1c, that 1) the CLDP was completed in a timely manner; 2) the CLDP demonstrated the individual and/or LAR agreed to service in the proposed setting; 3) the plan was developed and implemented in coordination with the Mental Retardation Authority (MRA); and 4) the CLDP specifies actions to be taken by the Facility and the responsible Facility staff, that these are reviewed as appropriate with the individual and LAR and that the prescribed steps are implemented as written, reviewed regularly and modified as needed. Under T1e, DSSLC reported it was in compliance with the requirements that the Facility verifies through the MRA or other means that the supports required in the CLDP are in place or that there was a plan for implementation of any non-essential supports that were not in place. Among these indicators, the only one the monitoring team found to be implemented consistently was the review of the CLDP with the individual and, as appropriate, the LAR/family. It should be noted that the Action Steps listed by DSSLC in the POI are not fully in congruence with components that are being reviewed. The POI relies largely on retrospective record reviews as evidence, and this may not be sufficient to assess the actual processes and outcomes that will be assessed by the monitoring team.
	Summary of Monitor's Assessment: DSSLC indicated that it was not in full compliance with any of the provisions of this Section but did report it had achieved some level of compliance in key component areas related to the CLDP, those being T1c and T1e. Assessment of these two areas was then the primary focus of this compliance visit. Since the Facility indicated it was not in compliance with the remainder of those provisions or with the other provisions as a

	whole, the monitoring team reviewed a sample of documents in order to be able to assess progress, if any, from the baseline tour and provide any additional recommendations that may be helpful to the Facility as it undertakes action in these provisions. The findings are as follows: **Provision T1:** This provision was determined to be not in compliance. This was generally consistent with the Facility's self-assessment. DSSLC had begun implementing the new statewide PSP process, but continued to need improvement in the areas of interdisciplinary assessment, individualized assessment of need for supports and services in the most integrated setting and development of individualized strategies for education about community living options to promote informed choice. The Facility reported it believed it was in compliance with some key indicators related to the CLDP. These included T.1.c and T.1.e. The monitoring team could not substantiate this compliance due to lack of timely completion of at least one CLDP and the failure to provide completed CLDPs in a timely manner prior to the transition as evidenced by MRA documentation that the full CLDPs were not available during the Continuity of Services visit. The Facility reported it was not in compliance with component T1h, the issuance of the Community Placement Report at required six month intervals. The monitoring team found that the Facility did collect all the required information but had not assimilated it into the required report. The monitoring team suggested that other documents the Facility had produced could be combined to create the Community Placement Report, and a final document was provided prior to the end of the site visit. Overall, the Facility would appear to be in substantial compliance with this component. **Provision T2:** This provision was determined to be not in compliance. The monitoring team found that the Post-Move Monitor was diligent in her efforts. PMM Checklists were being completed in a timely manner, for the most part, but not universally. There appeared to be some potential for PMM visits to be missed when the process takes place across catchment areas, and the Post-Move Monitor from one SSLC is responsible for the PMM visits for an individual from a different SSLC. There was one such instance found during this compliance visit, and it is an issue that has potential to grow as more individuals move to community settings in other catchment areas. **Provision T3:** This provision does not require a compliance review as it merely acknowledges that certain individuals who are at the Facility for court-ordered evaluations are exempt from the provisions of Section T. **Provision T4:** This provision was determined to be not in compliance. The Facility acknowledged in the POI a need to have policy and procedure that defined how it would identify and implement alternate discharges consistent with CMS-required discharge planning procedures, rather than the provisions of Section T1d, and T1e, and T.2, for the individuals who are classified in the SA as alternate discharges. Such alternate discharges could occur at any point, and the Facility should have policies and procedures in place to define its processes. Its plan, according to the POI, was to update its local policy and procedure once

	anticipated updates to the statewide policy on Most Integrated Setting are completed.

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T1	**Planning for Movement, Transition, and Discharge**	This provision was found to be not in compliance.	N
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	This component was found to be not in compliance. Ten individuals were reported to have been placed in the community since January 2010, but with only four of these placed since the last site visit in April, 2010. This amounts to less than 1% of the population transitioning to the community in the past six months, and is at a pace well below that of most other SSLCs. DSSLC had undertaken a number of initiatives that were intended, at least in part, to assist PSTs to more effectively implement their responsibilities to encourage and assist individuals to move to the most integrated settings appropriate to their needs. • A QMRP Educator had been hired whose singular role it was to monitor and train QMRPs. • The QMRP manual had been updated. • Active Treatment Coordinators had been designated for each residence. Their roles included the scheduling and coordination of community tours and other community activities. • DSSLC had recently implemented the new statewide PSP process that was designed to make the identification of supports and services, in any setting, more person-centered. Training in this new Supporting Visions curriculum had been ongoing at the Facility since 8/23/10. According to the Report to Monitors provided at the entrance meeting, 377 staff had been trained in the new process. It remains to be seen whether this new process will result in any enhancement to the ability of PSTs to assess the supports and services needed by individuals in the most integrated setting. • The Facility had also begun monitoring the PSP process. • The Contract MRA continued to implement the annual CLOIP assessment and arrange for CLOIP tours.	N
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	This component was found to be not in compliance. New statewide policies had been issued in conjunction with the roll-out of the statewide PSP process, but these were not yet incorporated into Facility policies and procedures. New statewide policies, procedures and processes were also reported to be pending for the CLDP and PMM, but these had not yet been finalized. To assess progress and compliance in this area, the	N

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	policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	monitoring team attended two PSP meetings and reviewed another 12 PSPs, including 5 that were developed under the new PSP format. The monitoring team also had the opportunity to review the curriculum for the Supporting Visions PSP training and the supporting statewide policy and procedure, and to attend a Supporting Visions training class. New statewide policies and processes around the CLDP were also on the verge of being rolled out. All of these processes were very new or not yet completely implemented. The monitoring team therefore reviewed these components with an understanding that it will take some time for them to mature and be ready for a thorough evaluation as it relates to compliance.	
	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.	The new PSP process was predicated on beginning with a vision for the individual as the basis for identifying the supports and services 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. This vision was intended to be developed through the Personal Focus Assessment (PFA), completed by the individual, family and PST during the third quarter preceding the annual PSP. This revised PFA had not yet been implemented to an extent that would allow for it to be assessed. The monitoring team looks forward to observing this process as it moves forward. A note of caution should be sounded, however, as to whether the PFA should or could be seen as a singular vehicle for envisioning an individual's future, or preparing an individual to participate in his or her won planning in a meaningful way. Individuals with intellectual disabilities may benefit from repeated and ongoing experiential activities as opposed to once or twice a year. The State and Facility should consider how it might expand on the PFA process to be an ongoing process that truly supports individuals to be active participants in their own planning. There continued to be a significant disconnect about the responsibilities of the PSTs to provide their professional assessment of an individual's most integrated setting in relation to the requirements of ADA and Olmstead. It was not clear the PSTs had received specific instruction as to this responsibility, and it was not incorporated in the Supporting Visions training. As a result, the PSTs seemed to have understood the new training as something that *replaced* a most integrated setting assessment (or at least discussion) rather than complementing and informing it. The new process, as observed in two PSPs during the site visit and in the documentation for five PSPs completed using the new process, did appear to succeed in focusing the PST on preferences of the individuals and how action plans might be developed to support those preferences. However, potential negative outcomes of failing to first identify a broader vision for the future were evident in the observation of the two PSPs. The teams	N

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		were not able to integrate the discussion of personal preferences with a broader vision of lifestyle in the most integrated setting. Their optimal living vision focused on foodstuffs, activities and items. They seemed to understand they had been instructed to focus on these preferences as the things that would ensure an optimal living vision regardless of the environment, so defining the most integrated environment appropriate to the person's needs was not given the same attention it had received when community living options (as opposed to an optimal living vision) was a required segment. In other words, addressing "community living options" did not migrate well to the "optimal living vision." The Supporting Visions training observed during the monitoring visit did not assist PST members to comprehend the development of a vision for the individual's future that would be a meaningful and holistic picture of a life well-lived in an appropriately defined most integrated setting. • For example, for Individual #562, much of the emphasis of the meeting centered on the individual's preferences for Pepsi. During the same meeting, the individual expressed a desire to move to a community setting. In the face of opposition from his LAR, the PST did not pursue this interest. The PST seemed comfortable addressing the desire or Pepsi, but did not seem to know how it might examine this stated interest to understand what the individual might find attractive about a community setting, and how the team could build on those lifestyle interests. • In the same vein, for Individual #705, the PST focused on certain preferred activities, but failed to grasp the perhaps larger significance of the individual's preference for small group and 1:1 attention, including how this might impact the individual's experience of social relationships and how a living environment might need to be structured. The monitoring team expressed concern that this approach might result in a rote consideration of preferences identified in the PFA that would not be integrated into the training and supports that would expand opportunities for participation in more integrated and preferred settings. With that said, the two PSPs attended still seemed likely to result in more focus on an individual's preferences, and could serve as a basis for developing a fuller vision of a desired life. The PST members and families who attended seemed energized by the focus and were creative in their approaches to addressing the identified preferences. The family/LAR of Individual #705 indicated in an interview following the PSP meeting that this was by far the best and most positive PSP they had ever attended. This is an important step, but DADS and the Facility will need to guard against the PSP becoming superficial in its focus.	
	2. The Facility shall ensure the provision of adequate	Since the last monitoring visit, DSSLC had engaged in some educational activities about available community placements to individuals and their families or guardians to enable	N

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	education about available community placements to individuals and their families or guardians to enable them to make informed choices.	them to make informed choices, but these have been rather limited in scope. A two hour Provider Fair was held on 9/10/10. It was attended by 25 providers, 97 staff and 9 attendees identified as "others." According to the Director of CFR, none of the participants from the latter category were family members or LARs for individuals who live at DSSLC. The Provider Fair was also attended by 40 individuals who live at the Facility. Given that the total population of DSSLC stands at over 500 individuals, the number of individuals attending the brief Provider Fair represented less than 10% of the population. The Contract MRA had continued to provide the annual CLOIP assessment. For 12 of the 12 PSPs reviewed, the CLOIP interview and Worksheet had been completed for each. There had also been community tours, but these had not been numerous. Since the last monitoring visit in April, 2010, a total of 34 individuals had attended a CLOIP tour. This number of visits was small even though the Facility had added a designated Active Treatment Coordinator for each residence who is responsible for arranging the tours, and the addition of six minivans to ensure transportation was available. The Facility had not taken full advantage of other potential opportunities for providing education and increasing awareness about community placement. For example, a review of the self-advocacy minutes since the last monitoring visit revealed that only one meeting addressed community options, in that case related to community employment opportunities. In addition, a review of the Orientation and Pre-Service curriculum indicated that no time was devoted to community living options. As evidenced in 2 of 2 PSPs observed, the PSTs were not well prepared to provide families and LARs with adequate information to make an informed decision about community placement. The following examples demonstrate the need for further education of PST members: • For Individual #705, the parents are the LARs. Both parents attended the PSP, as did the individual's sister. During the meeting, the individual's mother expressed the family's adamant opposition to community placement, citing the individual's many years at DSSLC. Also during the meeting, there was discussion about how the individual responded well to small settings and one-to-one attention but would not remain at activities that were in large group settings. In an interview following the meeting, the family indicated that no team member had ever suggested to them that the small group settings available in a community setting might better fit the individual's needs and preferences, and that they could see this as a possible advantage. This does not suggest that the family was then inclined to support community placement; however, it does	

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		demonstrate that families and LARs may be receptive to learning more about the potential of community living when it is presented in a non-threatening environment and is specific to the needs and preferences of each individual. • For Individual #562, the individual's sister is the LAR. She attended the PSP. She was on record as opposing community placement, at least in part because of previous negative experiences with such a placement. She repeated her opposition during the meeting. At one point, the individual was asked where he wanted to live and he stated "in the community." This surprised the team, but it was attributed to the guardian having allowed the individual to be visited by the CLOIP service coordinator for the first time. When asked further if the individual might visit group homes, the sister said no. The team did not pursue the subject further. In an interview following the PSP meeting, the sister asked the individual again where he wanted to live and he again stated "in the community." The sister was again surprised and asked another way, posing the question as to whether the individual liked living at DSSLC. He replied "Not really." At this point the sister indicated she would have to reconsider and speak to the rest of the family about the individual's stated wishes. In further conversation, she indicated that she was not aware that she could accompany the individual on community tours or even take tours on her own. She also was not aware of the team's role in helping her and her brother design the type of setting, supports and services that would best meet his needs in the community. Her previous experience, some years ago, had been that her brother had to fit into the available placements, not that a community placement could be designed to meet his needs.	
	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	DSSLC provided a description of its process for assessment, stating that all "individuals are assessed for community placement through the Living Options discussion. At this time, the team discusses the supports that would be required if the individual chose to move to a more integrated setting. All aspects of an individual's support services are discussed with prioritization given to their preferences. During this process the team discusses the awareness of the individual and/or LAR about living options that are available and the preferences they have for a specific option. The team will discuss what obstacles are identified as a barrier to a less restrictive setting. This is done through the identification of supports and services needed by the individual in specific areas such as education about living options, living environment, day programming, transportation, OT/PT, speech, Medical, behavioral, psychiatric and rights/restrictions. If the team identifies obstacles that are not addressed through the Personal Support Plan itself, they are tasked to create action plans to remove the identified obstacle. Ideally, the individual, LAR, team, designated MRA must all be in agreement about a recommended choice of living option. However, it is clear that an LAR decision is final in this area of	N

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	practices.	service decisions." The Facility provided a list of 544 individuals who had been assessed for placement since 9/09, using this definition. From observations and document reviews as described in T1a and T1b above, the Community Living Options discussion did not appear to be implemented in such a manner that it could yet be considered an effective assessment for placement. In some respects, the new statewide PSP process seems to have curtailed that discussion rather than enhanced it. A number of improvements should be made to how the process is implemented before the facility begins to consider that individuals have been truly assessed for placement.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	This component was found to be not in compliance. The Facility reported it believed it was in compliance with this component and its subsections. The monitoring team could not substantiate this compliance due to lack of timely completion of at least one CLDP and the failure to provide completed CLDPs in a timely manner prior to the transition, as evidenced by MRA documentation that the full CLDPs were not available during the Continuity of Services visit. Examples include: • For Individual #381, it was noted that transition to the individual's chosen community placement would be taking place during the week of 9/27/10. On 9/28/10, the Director of CFR informed the monitoring team that the CLDP was not yet completed. An incomplete draft was provided for review. The Continuity of Care form completed by the MRA on 9/28/10 indicated the provider had a draft copy of the individual's CLDP, but the draft provided to the monitoring team was very incomplete and did not include a timeframe for the implementation of the non-essential supports. • For three of the seven Continuity of Care forms reviewed (Individuals #343, #348, and #688), the MRA documented that the site administrator/manager of the provider agency did not have a copy of the draft CLDP. It was noted that one of these was for an individual (#343) whose transition occurred very quickly at the family's request, but even if this one was discounted, two of seven providers not having the draft CLDP would indicate a potential concern that providers cannot be adequately prepared to provide the needed supports and services. It was noted that DADS was in the process of rolling out a new set of procedures for the CLDP, which would make some significant changes. These included that 1) the CLDP would begin with the initial referral for community placement, 2) that the Facility would ensure that all essential supports and services were in place prior to transition instead of delegating this responsibility to the MRA and 3) that the CLDP process would	N

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		incorporate the PMM process. There were also to be new formats and expectations for the CLDP and PMM Checklists. These were positive steps toward ensuring that transition planning will be comprehensive and well-integrated across the entire process. The remainder of the review of the components related to CLDP was made with the understanding that the process would be undergoing a significant transformation, and that this would require an assessment of these revised processes during future visits.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	For three of seven CLDPs reviewed using the existing processes, the listing of essential and non-essential supports did not adequately capture basic requirements for a successful transition. Examples included: • For Individual #620, the essential and non-essential supports and services section consisted of a series of lined-out items and responsible persons for another individual, although Individual #620's name was on each page. • For Individual #516, the CLDP included assessment information that called for the provider to continue to use a shower chair with a seat belt, tub bench with seat belt or a Parker tub. The essential supports did not address the presence of this equipment, instead calling for grab bars in the tub. The essential supports also called for an inservice on the Physical and Nutritional Management Plan but did not detail the specific assistive equipment the individual requires, including wheelchair, rolling walker and eating equipment. No essential or non-essential supports were identified in the areas of social, leisure, safety or religion. • For Individual #343, there were no essential supports identified. This was perhaps due to the individual moving home directly from a hospital stay, resulting in a need to hastily develop a CLDP after the actual move. Since essential supports are defined as needing to be in place prior to the transition, the team may have decided to identify all supports as non-essential, or those that could be put into place following the move. Although the CLDP identified the need for a behavior support plan due to the "intensity" of self-injurious behavior, this was not found in the listing of supports. The CLDP process is a continuation of the Facility's responsibility to assess the needs of an individual who will be moving to a more integrated community setting, and to ensure that the community setting adequately meets those needs. The identification of essential and non-essential supports must begin by considering those things identified in the PSP. The potential problem with this was that it was not clear the PSTs were proficient in overall needs assessment, the interdisciplinary process necessary to integrate the assessment findings into a comprehensive support plan, or finally, the identification of the supports and services needed and desired in a community setting during the PSP, as described in Provision T1b. Examination of this item of the Settlement Agreement will	N

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		therefore be contingent to some degree on a positive evaluation of Provision T1b at some point in the future.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	In five of seven CLDPs reviewed using the existing processes, DSSLC did not assign specific Facility staff responsibility for all essential and non-essential supports. Instead, staff from the selected provider were identified rather than Facility staff. It was not clearly stated that Facility staff had any responsibility to monitor or follow up with the designated provider staff to ensure implementation and/or timeliness. Facility policy and procedure should specify the expectations in this regard, that CLDPs should assign responsibility to Facility staff to ensure that all required activities are completed, even if a provider or MRA staff has primary responsibility for the activity	N
	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.	For seven of the seven CLDPs reviewed using the existing processes, it would appear that the plans were 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, as evidenced by signatures and specific documentation of participation in the meeting minutes.	SC
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.	Compliance could not be substantiated for this component. The monitoring team did not receive a comprehensive assessment of needs and supports for each of the CLDPs reviewed. For two of the seven CLDPs reviewed using the existing processes, the comprehensive assessment was reviewed. For Individual #343, the move to the parents' home was unanticipated and therefore the Facility was not able to prepare in advance. A complete packet of existing assessments was provided after the move had occurred. For Individual #381, a packet of comprehensive assessments had been prepared, but the transition was delayed at the time if the site visit, which may require the assessments to be updated again once a new transition date is set. The Facility indicated that it was not in compliance with this component. The monitoring team will review it in more detail at the next site visit.	N
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	This component was found to be not in compliance. For Individual #381, the draft CLDP (using the new format) provided to the monitoring team was very incomplete and did not include a timeframe for the implementation of the non-essential supports. Although the MRA confirmed that the provider had a copy of this draft CLDP, its incompleteness would have made it very difficult to develop a plan setting forth the implementation date of such supports. This individual's transition had to be delayed at the last minute as essentials supports were not available. The Director of CFR stated that the new CLDP process would call for the Facility to verify	N

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	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.	for itself, rather than relying on the MRA, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety are in place at the transitioning individual's new home before the individual's departure from the Facility. This was confirmed by the draft CLDP procedure provided to the monitoring team by the DADS Continuity of Services Coordinator.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	This component was found to be not in compliance. The Director of CFR reported that the Facility had not yet developed or implemented quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section.	N
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,	This component was found to be not in compliance. The Facility did not provide any documentation that it gathered and analyzed obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. It is expected that the Facility will gather obstacle data on a comprehensive basis, perform some type of analysis or interpretation of the data (i.e., a comprehensive assessment), such as a narrative in which they can provide more depth to the straight numbers, and provide that information to DADS on an annual basis. The analysis should be predicated on a consistent methodology for collecting information that is described at the outset of the report. Examples of possible sources for relevant data that could inform a truly comprehensive assessment include: • Barriers perceived and/or encountered by individuals, families and LARs, as documented by the PSTs and through Parents and Self-Advocacy groups • Post-Move Monitoring Checklists could be analyzed and common issues identified. Since DADS is responsible under this component to take appropriate steps, based on the Facility's comprehensive assessment, to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, it may be helpful for the State Office to provide some guidance to the Centers as to this methodology in order to ensure it receives comparable data from each one.	N

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	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 monitoring team is aware that DADS is in the process of drafting its initial compilation and analysis of the obstacles identified by all of the SSLCs, and will look forward to reviewing it when available.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services 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.	No document was provided to the monitoring team in response to this item in the document request. DSSLC clearly had collected the information needed to provide the requirements of the Community Placement Report, to wit: those individuals whose IDTs have determined, through the PSP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. These data had been provided separately in response to other items in the document request. The monitoring team suggested to the Director of CFR that other documents the Facility had produced could be combined to create the Community Placement Report, and this document was provided prior to the end of the site visit. The Community Placement Report covered the period of 3/1/10-9/1/10 and included six individuals who had transitioned to a community placement and ten individuals who had been referred by their PSTs. The Facility would appear to be in substantial compliance with this component, as it collects the necessary information and had produced two separate documents that, combined, would meet the intent of the requirement. In the future, the Facility should ensure that the data are compiled and issued as the Community Placement Report as required.	SC

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T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**	This provision was found to be not in compliance.	N
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	This component was found to be not in compliance. The monitoring team found that the Post-Move Monitor was generally diligent in her efforts. PMM Checklists were being completed in a timely manner, for the most part, but not universally. For one of 15 individuals (#110) for whom PMM checklists were reviewed, the prescribed 90-day Checklist was not provided. There also appeared to be some potential for PMM visits to be missed when the process takes place across catchment areas, and the Post-Move Monitor from one SSLC is responsible for the PMM visits for an individual from a different SSLC. There was one such instance found during this compliance visit, and it is an issue that has potential to grow as more individuals move to community settings in other catchment areas. • For Individual #470, the initial PMM visit did not take place until 28 days after the transition date. This individual was a minor, with a history of substance abuse while in the care and custody of his family. A number of non-essential supports related to this history were designated to be in place within seven days of transition, including drug testing following any home visit. The Post-Move Monitor at DSSLC was not notified of the transition, which occurred on 7/2/10, until 7/20/10. The Post-Move Monitor made an initial contact with the provider on 7/22/10 and discovered that the individual had been with his family since 7/20/10. He returned to the provider home on 8/1/10, but an initial visit was not scheduled until 8/12/10. Given the potential risks for this individual, this failure to provide timely PMM could have proven to be very problematic It was reported by the PMM that this example of late notice of a transition was not an isolated occurrence. This may have been the responsibility of the sending Facility. At the same time, the receiving Facility is also responsible to ensure that once it does receive notification, it is acted upon in a timely manner. An additional ten day lapse in actually seeing the individual may not have been reasonable under the circumstances of this potentially high-risk situation. Policy and careful procedure should be developed and implemented to ensure critical visits do not fall through the cracks. There were also instances in which the PMM failed to follow-up, or having made an initial step at follow-up, failed to close the loop and document the resolution of the concern or need. For 3 of 5 PMM Checklists of individuals being monitored on behalf of other SSLCs,	N

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		there were instances of a lack of documentation of such needed follow-up by the PMM. Examples included: • For Individual # 796, the PMM Checklist for the 7-Day visit on 8/19/10 indicated there was no documentation of staff training. A note said that the provider indicated the in-services were being completed later in the evening of 8/18/10 with all home and day program staff. No follow-up was noted nor a plan to follow-up set forth, • For Individual # 16, the PMM Checklist for the 7-Day visit on 8/24/10 documented that there was no documentation of staff training. On 8/31/10, follow-up was made to request documentation of in-service, but no documentation was made to indicate this had been received. In addition, following an incident of unauthorized absence by the individual, the PMM indicated that she would contact the other SSLC to obtain a risk assessment. There was no further documentation that this had been received and made available to the provider. • For Individual # 465, an essential support stated that the provider would continue to use the communication dictionary. This support was checked in the affirmative, but on the following page it stated there was no documentation that staff had been trained in the individual's communication needs. It was not clear what follow-up action was to be taken. For four of ten individuals from DSSLC who were receiving PMM from either DSSLC or another Facility, there were also instances of a lack of documentation of needed follow-up by the PMM. Examples included: • For individual #516, the CLDP listed a variety of supports needed related to assistive equipment, but these were not translated to the listing of essential supports and services. The Post-Move Monitor failed to identify that these supports were identified elsewhere in the CLDP and did not document that they were available. The Post-Move Monitor must be familiar with the entire CLDP and share a responsibility for ensuring that the PMM Checklist captures all of the supports and services an individual need for a successful community placement. • For Individual #620, there were concerns expressed by provider staff as to the use of adaptive equipment. The Post-Move Monitor documented follow-up with the case manager, who stated that a team meeting would be held to address these concerns. The Post-Move Monitor requested that the evidence of this meeting be provided when available, but there was no documentation that this evidence was obtained. • For Individual #400, the Post-Move Monitor documented during the 90-Day visit	

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		that the individual was lethargic and had difficulty sitting and standing. It was documented that the Post-Move Monitor contacted the provider nurse, who, in turn, stated she would check on the individual. The Post-Move Monitor did not document that this intervention occurred or what the outcomes related to the individual's health status might have been. .	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	The evidence for this component was insufficient to substantiate compliance, particularly given the findings in section T2a above in terms of the PMM process. The monitoring team accompanied the Post-Move Monitor on one 90-day monitoring visit for one individual, who had moved to the community from Mexia SSLC. Prior to the visit, the CLDP was reviewed. The Post Move Monitor and the monitoring team representative were accompanied by the DADS Continuity of Services Coordinator. While the Post Move Monitor was clearly familiar with the needs of the individual and was thorough in her examination of the items in the CDLP, it was not clear that that all PMM visits had been as thorough. Other PMM visits documented in T2a indicated that there are some concerns as to the thoroughness of follow-up activity required to ensure resolution of potential problems. In order to substantiate actual compliance with this component, additional PMM visits will need to be observed.	N
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.		Not Rated
T4	**Alternate Discharges -**	This provision was found to be not in compliance.	N
	Notwithstanding the foregoing	The Facility reported no alternate discharges had taken place since the last monitoring	

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	provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	visit. The Facility did not have policy and procedure that defined how it would identify and implement alternate discharges consistent with CMS-required discharge planning procedures, rather than the provisions of Section T.1 (d), and (e), and T.2, for the individuals who are classified in the SA as alternate discharges. Such alternate discharges could occur at any point, and the Facility should have policies and procedures in place to define its processes. In the POI, the self-prescribed Action Step required the SSLC to develop policies/procedures governing most integrated setting that include all SO requirements and additional facility specific requirements. At a minimum, it was expected the SSLC policy/procedure would address all the components for CMS required discharge procedures as described in the SA. The Facility indicated it planned to update its local discharge policy and procedure upon anticipated statewide policy updates.	

Recommendations:

1. The Action Steps listed in some portions of the POI were based on achieving 100% compliance in record reviews; however, the requirements of some components would not seem to lend themselves to record reviews, even for the purpose of providing evidence of compliance, much less as a plan for achieving compliance. The Facility and DADS may want to review these Action Steps.
2. The new PSP process, as implemented during this site visit, seemed likely to result in more focus on an individual's preferences, even though those may have been more mundane than visionary. The PST members and families who attended seemed energized by the focus and were creative in their approaches to addressing the identified preferences. This is an important step, but DADS and the Facility will need to guard against the PSP becoming superficial in its focus.
3. The new PSP process may have an unintended effect of curtailing the discussion of community living options and obstacles thereto, as these were

minimally addressed in the two observed PSPs and the sample of five of the new format that were reviewed. Additional attention will need to be given to ensure that the living options discussion remains at least as robust as in the prior format.

4. DSSLC is taking some actions to increase education and awareness about community living options, but these do not appear to have been well thought-out with clear goals in mind. The Facility should develop a comprehensive strategic plan for such education with assigned responsibilities, timelines and outcome measures. The Facility should take full advantage of the variety of potential opportunities for providing education and increasing awareness about community placement, including, but not limited to, increased community tours; new employee orientation and ongoing training to ensure PST members are prepared to assist individuals, families and LARs to make informed decisions, and self-advocacy activities.
5. The revised PFA had not yet been implemented to an extent that would allow for it to be assessed. The monitoring team looks forward to observing this process as it moves forward. A note of caution should be sounded, however, as to whether the PFA should or could be seen as a singular vehicle for envisioning an individual's future, or preparing an individual to participate in his or her won planning in a meaningful way. Individuals with intellectual disabilities may benefit from repeated and ongoing experiential activities as opposed to once or twice a year. The State and Facility should consider how it might expand on the PFA process to be an ongoing process that truly supports individuals to be active participants in their own planning.
6. In the CLDPs, it was not clearly stated that Facility staff had responsibility to monitor or follow up with the designated provider staff to ensure implementation and/or timeliness for all essential and nonessential supports. Facility policy and procedure should specify the expectations in this regard.
7. There was some potential for PMM visits to be missed when the process takes place across catchment areas, and the Post-Move Monitor from one SSLC is responsible for the PMM visits for an individual from a different SSLC. This is an issue that has potential to grow as more individuals move to community settings in other catchment areas. Policy and careful procedure should be developed and implemented to ensure critical visits do not fall through the cracks.
8. Since alternate discharges could occur at any point, the Facility should develop and implement policy and procedure that defines how it would identify and implement alternate discharges consistent with CMS-required discharge planning procedures, rather than the provisions of Section T.1I,(d), and (e), and T.2, for the following individuals:
   (a) individuals who move out of state;
   (b) individuals discharged at the expiration of an emergency admission;
   (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe;
   (d) individuals receiving respite services at the Facility for a maximum period of 60 days;
   (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission;
   (f) individuals discharged pursuant to a court order vacating the commitment order.

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Denton State Supported Living Center (DSSLC) Plan of Improvement (POI), dated 5/17/10 2. DSSLC Supplemental POI, dated 7/6/10 3. List of individuals who have a Legally Authorized Representative (LAR) 4. Prioritized list of 197 individuals who are in need of an LAR 5. List of 17 individuals for whom an LAR has been obtained since 1/1/10 6. DADS draft Policy Number: 019 Rights and Protection (including Consent & Guardianship) 7. Personal Support Plans (PSP) and Rights Assessments for 15 individuals: Individuals #28, #42, #62, #102, #127, #392, #402, #404, #427, #601, #602, #606, #660, #727, #750 8. DSSLC Section U completed monitoring tools for 33 individuals: #49, #52, #55, #89, #94, #130, #151, #170, #191, #199, #210, # 238, #272, #279, #291, #332, #390, #404, #425, #438, #514, #532, #549, #570, #600, #629, #650, #674, #704, #705, #732, #749, #774 **People Interviewed:** 1. Andy Maher, Director of Consumer and Family Relations (CFR) 2. LAR for 2 individuals: Individuals #562, #705 **Meeting Attended/Observations:** 1. PSPs for 2 individuals: Individuals #562, #705
	Facility Self-Assessment: The Monitoring team reviewed the DSSLC POI and Supplemental POI. The POI indicates that the DADS State Office Policy Unit will be responsible for the development of statewide policies, procedures and practices that will provide guidance to the facilities in these requirements of the SA. A draft policy, Policy Number: 019 Rights and Protection (including Consent & Guardianship), has been promulgated and was under review at the time of the monitoring site visit. The POI stated that Facility policies, procedures and practices in this area would be developed following the final issuance of the statewide policy. The Supplemental POI listed some of the actions the Facility had taken or was planning to take to address recommendations made at the time of the last monitoring visit, including the hiring of two Human Rights Officers who will serve as content experts around guardianship issues for the Facility and the planned development of a guardian workshop to educate staff. Both of these steps are commendable. DSSLC indicated it was not yet in compliance with any of the provisions for Section U, as it was awaiting the final guidance in the form of the DADS statewide policy. The monitoring team concurred with this assessment. It should be noted that the Action Steps listed by DSSLC in its POI are not fully in congruence with components that are being reviewed by the monitoring team. The POI relies largely on retrospective record reviews as evidence, and this may not be sufficient to assess the actual processes and outcomes that will be assessed by the monitoring team. Areas being reviewed by the Monitor's team are addressed in the Summary of the Monitor's assessments and findings section below.

	Summary of Monitor's Assessment: Since DSSLC did not indicate it was in compliance with any of the provisions of this Section, and particularly since it indicated it was waiting on the final statewide policy before taking most actions, the monitoring team reviewed a sample of documents in order to be able to assess progress, if any, from the baseline tour and provide any additional recommendations that may be helpful to the Facility when it does undertake action in these provisions. The monitoring team found that the Facility was taking a measured approach to the issues of guardianship as it awaited the promulgation of statewide DADS Policy Number: 019 Rights and Protection, and this is to be commended. Additional findings are as follows: **Provision U1:** This provision was determined to be not in compliance. The Facility had made no significant changes to its tools or processes since the previous monitoring visit, in anticipation of the issuance of the statewide policy. The Facility expected to operationalize this policy once it was made available. In the interim, the Facility did continue to maintain 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, but the placement of the individuals on the list was not made according to any standardized assessment or specific criteria. An informal prioritization process was being used, but it was expected that this would be modified according to the requirements of the statewide policy. DSSLC had begun to monitor the documentation of the PSP process as it related to discussion of the need for guardianship, which should provide it with a baseline snapshot of the skills of the PSTs in the assessment of ability to provide consent as it begins to operationalize the new statewide policy. These baseline data should be analyzed carefully, as they tended to confirm that the PSTs were not consistently addressing the actual decision-making capacity of individuals before recommending a referral for guardianship, nor were they routinely following up with making a referral once the recommendation has been made. **Provision U2:** This provision was determined to be not in compliance. The Facility had not made any substantial changes in this area since the previous monitoring visit; rather, it had adopted an appropriately deliberate and careful stance toward the solicitation of guardians. It was awaiting further guidance in this area from DADs in the form of the new DADS Policy Number: 019 Rights and Protection. The Facility anticipated it would begin to operationalize this policy on a local level once received. Again on an interim basis, DSSLC had taken some early initiative to arrange for training for guardians and potential guardians on the roles, responsibilities and expectations of guardians. In addition, it had hired two Human Rights Officers to assist with guardianship and other rights issue who were scheduled to assume their duties on 10/01/10. Both of these were appropriate steps, but the Facility will need to consider how to best use these resources and others in the implementation of the new policy.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and	This component was determined to be not in compliance. The monitoring team observed two PSPs, reviewed an additional 15 PSPs and Rights Assessments, and interviewed the Director of CFR to assess the Facility's status in this	N

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	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.	area. No state level policy was yet available to implement this section of the Settlement Agreement, but a draft policy, DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship), had been promulgated and was under review at the time of the monitoring site visit. DSSLC does have a facility-specific Policy and Procedure: Client Management 30, Guardianship, dated 3/10/09. No additional updates had been made to the Facility policy and procedure as they await the final issuance of the state-level policy. Currently, 372 individuals living at DSSLC had an LAR assigned. The Facility provided a prioritized list of 197 individuals who did not currently have guardians, but may be in need of one. The Facility had not taken any action since the preceding monitoring visit to revise its processes or tools for assessing an individual's functional capacity to render a decision regarding the individual's health or welfare, or to its processes for referral for guardianship. For the two PSPs attended, both of the individuals had current guardians. There was no discussion during the PSPs as to their capacity to make decisions at any level, nor any discussion as to actions that might be taken by the team to restore capacity in any area. The monitoring team also reviewed PSPs and Rights Assessment documents for an additional 15 individuals. • For 15 of 15 Rights Assessments, in the section related to informed consent, all six categories were checked to indicate the inability of the individual to give consent in that area. • For 11 of 15 Rights Assessments, there were no PST comments or explanations for these determinations. • For 4 of 15 Rights Assessments, when PST comments were made as to the basis for the determination, the comments did not describe any specific criteria upon which the determination was based. • For 15 of 15 of the corresponding PSPs reviewed, there was no discussion as to any specific capacities of the individual to make any type of decisions on his/her own behalf. A review of the draft DADS Policy Number: 019 Rights and Protection indicated this document will provide direction to the PST as to its responsibility to address decision-making capacity using a more discriminating methodology, as well as its responsibility to develop, as appropriate, strategies to restore or otherwise enhance the capacity of individuals to make informed decisions. There had also been no action taken by the Facility to formalize or revise the prioritization criteria it was using in maintaining its list of individuals lacking both	

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		functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision. These processes and tools are prescribed in the draft policy, DADS Policy Number: 019 Rights and Protection that was expected to be issued in the near future, so this was a reasonable approach. The monitoring team looks forward to reviewing these areas at the next site visit. DSSLC had begun to monitor the PSP processes for assessment and referral for an LAR. This is to be commended. The Facility provided 57 monitoring tools for review, using 3 separate formats. The first format was used for during a period from 2/10-5/10, and consisted of a record review focused on 2 indicators: whether the individual's need for a guardian or advocate was discussed or incorporated in the PSP and whether the Department of CFR had been notified of the recommendation resulting from the PSP. • For the 33 monitoring tools provided using this format, ten of 33 indicated the need for a guardian or advocate was not discussed or incorporated in the PSP. • For the 23 tools that did indicate discussion was held, 13 of 23 had current guardianships. For 13 of 13 of those, the guardianship section of the PSPs did not discuss the individuals' capacity to make decisions, but rather simply stated their current status. • For 10 of the 10 tools that indicated guardianship was discussed but that the individuals had no current guardian, there was little assessment of the actual need in this area. • Referrals to the Department of CFR were recommended in 15 PSPs. For 12 of the 15, referrals had not been received. In one instance (Individual #629), the PST documented in the PSP that the individual was "able to make decisions and communicate his wants and needs." It went on to state that he communicated with word, gestures and complete sentences. The PST then stated that the parents were currently seeking guardianship and that the team would send a referral to the Department of CFR to assist the parents. There was no discussion noted as to the apparent discrepancy between the team's affirmative assessment of the individual's ability to make decisions and the making of a referral for guardianship. Documentation of follow-up that occurred as a result of the above findings was provided for seven individuals. While there were still a number of findings in need of follow-up where no action was documented, this effort was an important step that should be formalized and expanded. Since June, 2010, the Facility had begun to use two different versions of the monitoring team's monitoring tools. The shorter version, which was a record review, did not always	

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		document the individuals whose records were reviewed and there was no evidence of follow-up to these findings. The longer version included the interview guides in a few instances. The responses to these interviews indicated action needed to be taken in some instances, but there was no documentation provided that such follow-up had occurred. • There were seven interview guides filled out for individuals served. Five of these stated the individual was nonverbal and unable to provide information and one indicated the individual did not have a guardian. The final one stated the individual had an advocate. This individual reported that he had not been asked if he wanted an advocate, nor who the advocate would be. When asked if the advocate asked his opinions and/or preferences about decisions, the reply was "sometimes." There was no indication of any follow-up provided that would ensure the individual's need/desire for an advocate and the advocate's role were congruent. • There were seven interview guides filled out for DSSLC staff. Three of these interviews were held with the Director of CFR. The purpose of this interview guide is to assess knowledge in the area of guardianship of a variety of staff, particularly PST members. It would provide little useful information as to the extent of staff knowledge to interview the Director of CFR, who has the primary responsibility for this area and would therefore be expected to be the best informed, on several different occasions. Of the remaining four interview guides for staff, two did not indicate the staff person interviewed, and two listed staff by name but not by position. It was therefore not clear whose knowledge was being tested. With that said, for four of four, the staff responded they did not know the facility's process for determining if an individual could give informed consent. When asked what role the PST plays in determining the need for guardianship, two of four responded they did not know and the other two responded that the team would send a referral to CFR. There was no reference to the PST's role in assessing the individual's need for a guardian in any of the four. In two of the four guides, the staff person administering the tool indicated staff retraining would be required, but there was no documentation provided of the retraining. These results seemed to indicate DSSLC needed to continue to improve both staff knowledge and Facility processes in the area of guardianship. The Facility's monitoring process for this provision was in its early stages and still evolving. Once the new DADS Policy Number: 019 Rights and Protection has been issued, the Facility should revise its monitoring indicators and processes to be consistent with the policy's requirements. There should be a consistent process for follow-up on individual issues identified, as well as process for tracking and trending those issues that would benefit from quality	

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		improvement activity.	
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.	This component was determined to be not in compliance. DSSLC reported it had not made any changes to its processes in the solicitation of guardians since the preceding monitoring visit, as it awaited the final issuance of DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship.) Since 1/1/10, 17 individuals had received a newly appointed guardian, including 2 individuals whose family obtained guardianship upon their reaching the age of 18. It was noted that one individual (#127) had been referred for community placement, but this referral was rescinded after a new LAR was appointed and objected to the placement. This was of concern because there has been some indication that guardianship is at times being obtained primarily to block community placement; however, according to the Director of CFR, this guardianship process was in process when the individual was admitted. According to the Director of CFR, most of the new guardianships did not come about as a result of a consideration of need for an LAR at a PSP meeting. As described in the preceding section U1, it is not clear that this referral process routinely leads to a PST's intention to make such a referral resulting in one reaching the Department of CFR. The Director of CFR stated that he does sometimes receive a referral slip as a result of a PSP meeting, but that he is not actively pursuing guardianships in most of these instances until the new DADS policy is issued. Until then, he was continuing to add the individuals to the prioritized list using his existing prioritization criteria. DSSLC had implemented one activity related to providing guidance on the process of becoming an LAR during this time period. As a part of the Provider Fair held on 9/10/10, the Facility included a one-hour workshop on guardianship presented by the Assistant Probate Court Investigator for Denton County. This was reported to have included the process for obtaining guardianship, the role of a guardian and the expectations of the court as to the duties and responsibilities of a guardian. While it was unfortunate that no family members or guardians of individuals living at DSSLC attended this training, it was a pro-active initiative of the Facility to make it available. The Facility may want to make this a recurring activity and publicize it thoroughly to family members, advocates and current guardians of individuals living at DSSLC. It would also be worthwhile to have PST members, particularly QMRPs, attend. DSSLC reported that two new Human Rights Officers (HRO) would begin work as of October 1. One of these is the current assistant Ombudsman at the Facility. According to the Director of CFR, much of the work of the HRO staff will be around guardianship issues, including tracking of expiring guardianships, assisting with documentation for	N

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		guardianship applications and renewals and planning for successor guardianships. It was not yet clear what role the HROs might play in the education of guardians, potential guardians and individuals who have either been identified as in need of an LAR or in the process of receiving an LAR, the Facility should consider how this resource might be used to provide ongoing education for each of these.	

Recommendations:

1. Facility PSTs should receive guidance and training from DADS to prescribe a process for how an assessment should be done to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond the areas needed by the person. Additionally, guidance should be provided as to how, and how often, a need for guardianship should be periodically reviewed. The pending statewide policy is expected to provide approaches in these areas.
2. Once the statewide policy and assessment process has been finalized, DSSLC should refine and develop facility-specific policies and procedures to operationalize the requirements.
3. The Facility should ensure its policy and procedure, once developed, include:
   - Clearly defined assessment and referral processes
   - Minimum criteria for individuals, organizations or entities the facility will solicit to act as an LAR for individuals, in order to assure individuals' rights and safety are protected.
   - The roles and responsibilities of the Facility in educating LARs and potential LARs in the roles and responsibilities of guardianship.
4. As a part of the Provider Fair, the Facility held a workshop on guardianship presented by the Assistant Probate Court Investigator for Denton County. This was reported to have included the process for obtaining guardianship, the role of a guardian and the expectations of the court as to the duties and responsibilities of a guardian. The Facility may want to make this a recurring activity and publicize it thoroughly to family members, advocates and current guardians of individuals living at DSSLC. It would also be worthwhile to have PST members, particularly QMRPs, attend.
5. Two new Human Rights Officers (HRO) had been hired at DSSLC and were set to begin work on 10/1/10. Much of the work of the HRO staff will be around guardianship issues. It was not yet clear what role the HROs might play in the education of guardians, potential guardians and individuals who have either been identified as in need of an LAR or in the process of receiving an LAR. The Facility should consider how this resource might be used to provide ongoing education for each of these stakeholders.
6. DSSLC has begun to monitor the PSP processes for assessing and recommending need for an LAR. This is to be commended. Once the new DADS Policy Number: 019 Rights and Protection has been issued, the Facility should revise its monitoring indicators and processes to be consistent with the policy's requirements. There should be a consistent process for follow-up on individual issues identified, as well as process for tracking and trending those issues that would benefit from quality improvement activity.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Denton Plan of Improvement (POI) 5/17/10 2. Denton Supplemental Plan of Improvement (SPOI) 7/6/10 3. DADS Policy 020.1 Recordkeeping Practices, dated 03/05/10 4. DSSLC Policy: Client Management-25 Recordkeeeping Practices, revised 5/18/10 5. DADS draft policy on At Risk Individuals 6. DADS Policy and Procedure Tracking Sheet 7. Active Record Order & Guidelines, Denton State Supported Living Center, revised 9/15/10 8. Master Record Purging Schedule 9/24/10 9. Denton Instructions for Chart Auditors, undated 10. Email memos from Melissia Steele to Records Clerks of 6/23/10, 62410, 6/25/10, 7/5/10, 7/6/10, 7/7/10, 7/9/10, 7/12/10, 7/13/10, and 7/14/10 including covers noting updates to records guidelines and miscellaneous instructions about actions to take 11. Agendas for Records Clerk Meetings of 6/15/10, 7/29/10, and 8/30/10 12. Emails documenting notice of errors identified in monthly monitoring, corrective actions needed, and corrective actions taken 13. Attendance Sheets for Record Keeping Practices training sessions of May, 2010, through September, 2010 14. Recordkeeping and General Plan Implementation checklist and Active Record Order and Guidelines with results of Facility audit of Active Record for Individual #381 on 6/25/10 15. Active Record for Individuals #32, #346, #381, #526, #586, #711, and #776 16. Partial Active Record reviews to check corrective actions for errors identified in monthly audits for Individuals #94, #153, #163, #323, and #659 17. Client Risk Info Card for Individual #526 18. DSSLC QA/QI Council Meeting Data Analysis Report 9/23/10 **People Interviewed:** 1. Melissia Steele, Unified Records Clerk 9/27/10 2. Betsy Knight, Client Records 9/28/10 3. Donna Freeze, QMRP, Nurse, and two Records Clerks at 508C 9/30/10 4. Lyndon Cotter, QMRP 502C 9/30/10 5. Assistant Home Leader 522D 9/30/10 6. Home Leaders at 511C 9/30/10 and 522D 9/30/10 **Meeting Attended/Observations:** 3. PSP for Individual #599 9/28/10 4. PSP Training Session 9/29/10 5. Discussion with Donna Jessee, Nancy Condon, Lori Powell, and Randy Spence regarding Facility and DADS policy on At-Risk Individuals 9/28/10

	Facility Self-Assessment: The Facility reported that no action steps in the Plan of Improvement except for the implementation of a quality assurance audit system are in compliance but that progress has been made in many areas. The monitoring team concurs. The Facility reported that the rollout of the new unified record is underway and scheduled to be completed in December, 2010. The QA/QI Council reported 87% of records have been converted. The monitoring team confirmed that nearly all records reviewed had been converted. However, the Individual Notebook component was still in flux, with several options being used. Furthermore, problems with selection of binders meant that there were different numbers of books for various individuals, which sometimes required looking through binders to see where the desired information could be found; it was in order but started and ended at different places that were not consistent across individual records. The Facility reported that policy was revised but not enough monitoring had occurred for long enough to ensure that the policy is being implemented in compliance with policy. The Recordkeeping policy had been revised, and audits indicated that it was not yet fully implemented. Furthermore, the actions identified in the POI related only to "an approved policy"—apparently, the policy for recordkeeping. Provision V2 refers to "all policies, protocols, and procedures as necessary to implement Part II of this Agreement." The Facility reported, and the monitoring team confirmed, that more than five records are audited each month but that not all audits assessed consistency with Appendix D of the SA nor did corrective action occur for all deficiencies. The monitoring team found that serious efforts are being made to implement and improve audits and to ensure that corrective actions are completed, but that not all corrective actions occurred timely, and there was no process in place to confirm reports of completed actions. The Facility reported that records go with the individual to all appointments at SSLC and staff record notes in the record, and that workgroups were meeting to make improvements in documentation. Although these are important steps, they will not by themselves lead to compliance. The use of records needs to be integrated into the processes of assessment, PSP development, and review of individual progress and status. These activities go far beyond the plans developed for improvement of Section V; actions to improve use of records must be integrated into other improvement planning and integrated with the procedures in the new PSP process.
	Summary of Monitor's Assessment: DSSLC made progress toward compliance with the requirements of this Section. The new recordkeeping policy and record format had been implemented for nearly all individual records. Training had been provided. An audit process had been put in place that included identification of deficiencies and a procedure to notify staff of corrective actions needed and to follow up on completion. Active Records still did not always include all required documents and had errors such as gaps on pages. Tracking and trending of such errors was not yet in place.

	Policy development and revision to support all provisions of Part II of the SA continued at both the statewide and Facility levels. Use of records for decision-making was variable. In some cases, multiple forms had similar information. Conflicts in information were not resolved. Behavioral program decisions were not supported by data. Not only do the data and other information in the active records need to be available and accurate, there must also be an expectation that the information will be reviewed, discussed, and used.

#	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.	DSSLC had established a unified record that includes an Active Record, and Overflow/Master Record. The new format established by DADS had been rolled out; the Facility reported that 87% of the records had been converted, and the monitoring team found only a few records in the prior format. The Individual Notebook component is still in flux; several formats were used across the Facility, including individual notebooks, group notebooks with information for up to four individuals, and Client Risk Info Cards. Records were consistent with requirements of Appendix D. Training on the new record format had been provided by the Unified Records Coordinators to home supervisors, administrators and management staff, QMRPs, nursing staff, records clerks, and direct contact professionals (DCPs). Training of records clerks included having them convert one record per home, It was much easier to find information in the current records than in the records at the baseline visit. Interviews with staff indicated that they generally agreed it was easier to find information. That was not always true, however. Two problems make it cumbersome to find the correct binder. First, in the past, two binders were used; the Program Record had a red binder, and the Medical Record had a green binder. All binders for the record are now blue, so there is not an easy way to make sure to pick up the correct binder. To correct for this, many of the binders now had colored dots to show which binder had which records—an orange dot where the Observation Notes are found and a blue dot on the book that contained the physician's orders. The second problem was that the binders were not large enough to have only two binders for all individuals; some records were large enough to require three or four binders. As a result, there was no way to be sure where in the record a binder ended and the next began. Because this often occurred somewhere in the medical information, finding the correct information could be more time-consuming for staff looking for that information. When asked, QMRPs and Home Leaders could easily find Active Records and the Individual Notebook components used in the homes where they worked. They could point out where specific information was to be found.	N

#	Provision	Assessment of Status	Compliance
		To determine whether Active Records were completed in compliance with Facility expectations and Appendix D of the SA, the monitoring team reviewed the complete Active Record (except for the Individual Notebook) for Individuals #381, #526, and #711 as well as the findings of the Facility audits for June, July, and August, 2010. None of the records met all the requirements. One of three was missing a Rights Assessment and one was missing Provision of Human Rights information. Three of three had gaps between entries in at least one section; these included progress records, observation notes, and physician order pages. Two of three had at least one record out of chronological order. One had an annual nursing assessment misfiled. In one record, numerous entries from what appeared to be one nurse over an extended time period were mostly illegible. The monitoring team conducted a full audit of the Active Records of Individuals #381 and #711, using both the monitoring checklist and the Active Record Order & Guidelines as used for auditing by the Facility. The ratings of the 9/30/10 audit by the monitoring team were compared with those from the 6/25/10 audit by the Facility. For the monitoring checklist items rated in relation to Provision V1 of the SA, the monitoring team found nine of the 11 items to be in compliance. The Facility audit had also found nine of those items to be in full compliance; item by item correspondence found two disagreements and nine agreements on specific items. This indicated good interrater agreement, at least for one record that was in relatively good condition. Checking agreement between the two ratings of the Active Record Order & Guidelines was more complicated because there had been an opportunity for corrections to be made after the Facility audit and because the monitoring team might not have understood precisely which documents were optional. Furthermore, these guidelines had been revised more than once in between the two ratings, so not all items were identical. Nevertheless, of 133 items rated by the monitor and the Facility, agreement was determined for 93 (70%). Of the disagreements, the Facility audit found 25 items acceptable that were not marked by the monitoring team. The monitoring team found 15 items acceptable that were not marked by the Facility. In some cases, these differences were clearly related to assessments that were either in compliance during the June audit but out of timeline by September or were completed and entered into the record after the June audit. This indicated a likelihood that the auditing definitions were adequate but also leads to a recommendation that interrater agreement be checked for a sample of audits. Other records reviewed also included misfiled information. The monitoring team found the medical care plan for Individual #118 in the Active Record for Individual #32. The annual medical evaluation for March, 2010, was missing from the Active Record for Individual #346. The monitoring team found a hospital discharge note for Individual #352 in the Active Record for Individual #776. Moreover, the audits conducted by the	

#	Provision	Assessment of Status	Compliance
		Facility found numerous errors. Nevertheless, progress had been made, and the Active Records were relatively usable, complete, and legible. If the auditing process reduces these errors, the Facility may meet the requirements of this provision when the rollout is complete. At the same time, the management of records was fragmented, with different organizational responsibility for the active record versus the Master record and the development of electronic records. People responsible for those two areas did not have all the information about what was happening in the other area. For example, different records clerks made different decisions about when to send documents to the records department for filing in the Overflow record; therefore, the Records manager did not know whether information was missing, because she did not know what was supposed to be received by her department. Moreover, staff who are working with DADS on developing an electronic record are not the same as the staff who had developed guidelines for the written record and trained staff. They had not discussed what will be needed to ensure all the information required in the written record will be included in an electronic record or how staff will be prepared for a conversion. As efforts are made to move toward an electronic record, the Facility needs to have a vision of how records will be used and how that will affect what is developed in forms, procedures, monitoring, and development of usable electronic records so that compliance with the provisions of this Section is maintained.	
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.	Both DADS and DSSLC had continued to revise and develop policies needed to implement the requirements of the SA. DADS provided a tracking sheet with status of policy revisions. As DADS policies are revised, Facility policies are also revised as needed to ensure compliance with DADS policy. Not all policies were yet revised to support all provisions of the SA, but progress had been made. For example: • DADS Policy 020.1 Recordkeeping Practices was implemented 3/05/10. DSSLC Policy: Client Management-25 Recordkeeeping Practices was revised 5/18/10. These policies meet the provision requirements for Section V (this section) of Part II of the SA. • The Facility developed a comprehensive policy on restraint use. • DADS reissued its abuse and neglect policies on 6/18/10. Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation and Policy 02.2 Incident management supersede Policy 02.1 which covered both topics. Policy 2.2 includes as an exhibit the Memorandum Of Understanding between DADS, OIG, and DFPS. These policies include changes resulting from recommendations from the monitoring team's baseline reviews and clearly reflect an absolute	N

#	Provision	Assessment of Status	Compliance
		prohibition of abuse and neglect and require timely reporting. DSSLC reissued its policies on 7/30/10 to reflect changes in the State policy. DSSLCs governing policies are now CMGMT 01A – Protection From Harm – Abuse, Neglect, and Exploitation, and, CMGMT 01B – Protection From Harm – Incident Management. • DADS Policy 003- Quality Enhancement was reviewed; it was consistent with the requirements of the Settlement Agreement (SA). Denton SSLC Policy CMGMT-15 Quality Enhancement Process, dated 1/5/10 guides the Facility's quality assurance processes. Section I-D of the policy describes data collection requirements. The POI reported this policy is under review to ensure it includes all necessary components to comply with DADS policy. • DADS was in process of revising the policy on At Risk Individuals. DSSLC had drafted a set of criteria for rating level of risk and had provided those draft criteria to DADS for review.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	The Facility had developed and implemented a monitoring process in May, 2010. Five or more records were reviewed each month by the Unified Records Coordinator (URC). Both the monitoring checklist for this section developed by the monitoring teams and the Active Record Order and Guidelines (which served as the table of contents for each Active Record) were reviewed for each audit. The URC documented on the Active Record Order and Guidelines the actual dates of many documents. This is a useful process and can help with follow-up. Deficiencies were identified, and notices of need for corrective action were sent. If notice of a completed correction was not sent to the URC, she sent a reminder message. In most cases, responsible staff notified the URC that correction had been made. The monitoring team reviewed completed monitoring checklists for 13 individuals. Out of 17 items checked for Provision V1, audits found a range of 10 to 16 items compliant. Documentation of follow-up requesting corrective action was found for 12 of the 13 audits. For seven of these, documentation was provided to the URC that corrective actions were completed. For one uncompleted action, documentation was provided to the URC of status and plan for completion. For the remaining five, there was no documentation of completion, even up to three months following the audit and following one or more reminder emails from the URC. Facility administrators will need to provide guidance and support to ensure that corrective actions are completed. There was no process to confirm that reported corrections had actually been made. The monitoring team checked six completed corrections in the Active Records of five individuals. All reported corrective actions were confirmed.	N

#	Provision	Assessment of Status	Compliance
		Trend analysis to identify needs for systemic improvements, retraining, or actions to correct widespread problems had not yet begun. The Facility needs to determine what information from record audits needs to become part of the overall Facility QA process.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	Use of records in making decisions was irregular. Currently, nursing and DCPs are utilizing five different forms to track basic areas of health care (i.e., vitals, bowel, temperature, intake, emesis, and weight). The use of multiple forms results in increased difficulty to draw conclusions and to clearly identify connections between these areas. This delay results in a possible delay in acquiring the needed data to expedite care. The new record format did not enable the user to readily access nursing clinical data, because the Annual Comprehensive Nursing Assessment was filed in the Program Assessment part of the record while the Quarterly Comprehensive Nursing Assessment was filed in the Medical section, . Additionally, there were numerous different types of nursing documents contained under the nursing tab. Most did not have individual tabs; if they did, the tabs were so small they were difficult to read and quickly locate. The Facility needs to evaluate the functional order of the records to ensure continuity of nursing data and develop a user friendly tab system, using larger tabs for nursing data that can be easily read and found. DSSLC made poor use of the data in monitoring efficacy of the PBSP. In 15 of 36 records reviewed, treatment decisions were not supported by available data or data clearly reflected poor treatment response with no following changes in PBSP. There was little focus in PSP and other meetings on using data from the records to make decisions. If records are useful, conflicts in information need to be identified and resolved. For example, there was no evidence the following example described in Provision J8 led to further review: Some chart documentation suggested that a joint understanding of cases was not in place. For example in the case of individual #289, the psychiatrist stated in the psychiatric assessment that the individual *"may be attempting to escape from disliked environments. Attention may be a secondary function."* In the PBSC of 01/22/09, however, the psychologist stated that "*the individual's anxious behavior seems functionally related to his psychiatric disorders… (The symptom) does not appear to help…avoid activities or gain attention.* "	N

Recommendations:

1. DSSLC should ensure it is easy to find information in the records, even if that requires purchase of new and larger binders and developing a process to identify at a glance which binder has which information.
2. The audit process should include periodic checks of interrater agreement.
3. The audit process should include checks of a sample of reported corrective actions to ensure they have actually occurred and that the corrective actions were done in a way that resolved the deficiency.
4. Tracking and trending of findings of the audits should become part of the Facility QA process and should lead to systemic process improvement plans.

List of Acronyms Used in This Report
Denton SSLC
September-October, 2010, Compliance Visit

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ACP	Acute Care Plan
AED	Anti-Epileptic Drug/Automated External Defibrillator
ADL	Activity of Daily Living
ADR	Adverse Drug Reaction
AIMS	Abnormal Involuntary Movement Scale
ANA	American Nurses Association
A/N/E	Abuse/Neglect/Exploitation
APC	Admissions/Placement Coordinator
APS	Adult Protective Services
BCBA	Board Certified Behavior Analyst
BP	Blood Pressure
BSP	Behavior Support Plan
BSRC	Behavior Support Review Committee
CBC	Criminal Background Check
CDC	Centers for Disease Control and Prevention
C-Diff	Clostridium Difficile
CFR	Consumer and Family Relations
CLDP	Community Living Discharge Plan
CLO	Community Living Options
CLODR	Community Living Options Discussion Record
CLOIP	Community Living Options Information Process
CMS	Centers for Medicare and Medicaid Services
CEU	Continuing Education Unit
CNE	Chief Nurse Executive
COP	ICF/MR Condition of Participation
CPR	Cardiopulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CSO	Campus Supervision Overnight
CTD	Competency Training and Development
CV	Curriculum vitae (resume)
DADS	Texas Department of Aging and Disability Services
DCP	Direct Care Professional
DD	Developmentally Delayed
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale

DOJ	U.S. Department of Justice
DMID	Diagnostic Manual-Intellectual Disability
DRO	Differential Reinforcement of Other Behavior
DSM/DSM IV TR	Diagnostic and Statistical Manual of the American Psychiatric Association
DSSLC	Denton State Supported Living Center
DUE	Drug Utilization Evaluation
EKG	Electrocardiogram
ER	Emergency Room
FA	Functional Analysis or Functional Assessment
FSPI	Facility Support Performance Indicator
FTE	Full Time Equivalent
FY	Fiscal Year
GERD	Gastroesophageal reflux disease
HCG	Health Care Guidelines
HCP	Health Care Plan
HIPAA	Health Information Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMP	Health Maintenance Plan
HOB	Head of Bed
HRC	Human rights committee
HO	Human Rights Officer
HST	Health Support Team
IBW	Ideal Body Weight
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IDT	Interdisciplinary Team
IMC	Incident Management Committee
IMRT	Incident Management Review Team
ISP	Individual Support Plan
i.v.	Intravenous
LAR	Legally Authorized Representative
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MBSS	Modified Barium Swallow Study
MD/M.D.	Medical Doctor
MOSES	Monitoring of Side Effects Scale
MRA	Mental Retardation Authority
MRSA	Methicillin-resistant Staphyloccus Aureus
NA	Not Applicable
NCP	Nursing Care Plan
NMT	Nutritional Management Team
NOO	Nurse Operations Officer

NP	Nurse Practitioner
OIG	Office of the Inspector General
OJT	On the Job Training
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
O2Sat	Oxygen saturation
PALS	Positive Adaptive Living Survey
PAO	Physical Aggression toward Others
P&P	Policies and Procedures
P&TC	Pharmacy and Therapeutics Committe
PBSP	Positive Behavior Support Plan
PBST	Personal Behavior Support Team
PCD	Planned Completion Date
PCP	Primary Care Physician
PDB	Physically Disruptive Behavior
PDP	Personal Development Plan
PFA	Personal Focus Assessment
PIC	Performance Improvement Council
PMAB	Physical Management of Aggressive Behavior
PMR	Psychiatric Medication Review
PMT	Psychotropic Medication
PRN	Pro Re Nata (as needed)
PNM	Physical and Nutritional Management
PNMC	Physical and Nutritional Management Coordinator
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
POC	Plan of Correction
POI	Plan of Improvement
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapy
PTR	Psychiatric Treatment Review
QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QI	Quality Improvement
QMRP	Qualified Mental Retardation Professional
RD	Registered Dietician

RN	Registered Nurse
r/o	Rule out
SA	Settlement Agreement
SAC	Settlement Agreement Coordinator
SAM	Self-Administration of Medication
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/Analysis, and Plan charting method
SSLC	State Supported Living Center
SPCI	Safety Plan Crisis Intervention
SPO	Specific Program Objective
SPOI	Supplementary Plan of Improvement
SQRA	Standard of Quality for Risk Assessment
STAT	Immediate
STD	Sexually Transmitted Disease
TB	Tuberculosis
UIR	Unusual Incident Review or Unusual Incident Report
VDB	Verbally Disruptive Behavior
VNS	Vagal Nerve Stimulator
VRE	Vancomycin-resistant enterococcus