United States v. State of Texas

Monitoring Team Report

Denton State Supported Living Center
March 28-April 1, 2011

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Table of Contents

Introduction

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 are 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.

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

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. However, the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members share information routinely and contribute to multiple sections of the report. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. Several sections of this report include information provided by multiple team members.

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.

Methodology

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

(a) **Onsite review** – During the week of the tour, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review.

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. 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.

Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement.

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

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

a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;

b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the SA. This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report. It should be noted that the Action Steps listed by DSSLC are a plan of improvement and may not be fully in congruence with, or may not at a given time address all, components of the SA that are being reviewed. The Assessment of Status by the Monitoring Team, therefore, reports on the findings of the monitoring team in relation to the provisions of the SA and may differ from the self-assessment by the Facility;

c) **Summary of Monitor's Assessment:** Although not required by the SA, a summary of the facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the facility has with regard to compliance with the particular section;

d) **Assessment of Status:** As appropriate based on the requirements of the SA, a determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement. Also included in this section are detailed descriptions of the Facility's status with regard to particular components of the SA and/or HCG, including, for example, evidence of compliance or non-compliance, steps that have been taken by the facility to move toward compliance, obstacles that appear to be impeding the facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;

e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; 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. 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. The recommendations for some provisions include a subsection of additional suggestions for the facility. These are presented in an effort to assist the facility in prioritizing activities as the facility staff work towards achieving substantial compliance with the provision.

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

Executive Summary

First, the Monitoring Team wishes to acknowledge and thank the individuals, staff, clinicians, managers, and administrators of the Facility for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the onsite monitoring review. The Facility made available to the Monitoring Team and number of staff members in order to facilitate the many activities required, including setting up appointments and meetings, obtaining documents, and answering many questions regarding facility operations.

The Monitoring Team would like to express appreciation to all the staff who provided assistance, gathered and made available documentation, took time to meet and answer all our questions, and made it possible for us to make determinations on compliance. The Monitoring Team was especially appreciative of the efforts of the Settlement Agreement Coordinator, Sheila Carpenter, Katie Thompson and the many other staff who assisted in gathering information and making arrangements.

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 the Facility. 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 and clinicians. 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.

As a result, a great deal of information was obtained, as evidenced by this lengthy and detailed report. Numerous records were reviewed, observations conducted, and interviews held. Specific information regarding many individuals is included in this report, providing a broad sampling from all homes and across a variety of individual needs and supports. It is the hope of the Monitoring Team that the information and recommendations contained in this report are credible and helpful to the facility.

As noted in this report, the Facility made significant progress in a number of areas. In a number of areas in which improvements are needed, the Facility had developed and begun to implement plans. The following provides brief highlights of areas in which the Facility was doing well, was making improvements, or needed to take action to improve.

Improvements and Positive Practices: Following is a brief summary of some of the improvements and positive practices noted during this visit.

<u>Restraints</u>

- Crisis intervention restraint use at DSSLC was trending down.
- The Facility's Restraint Reduction Committee had become more active and meeting content appears to be substantive, including case presentations for roundtable discussion.

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Abuse, Neglect and Incident Management

- 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 has had an obvious effect on the quality of some investigations.
- To facilitate abuse/neglect reporting, the Facility put in place a three digit number in its phone system that automatically connects with DFPS. This enables staff to remember a three digit number and have quick access to DFPS to report allegations.

Quality Assurance

- The Facility continues to make progress in the development of a QA process that is intended to measure ongoing compliance with the requirements of the SA. A Quality Assurance Plan had not been formalized but the shell reviewed during the last monitoring visit had been expanded and refined. Compliance Reports were routinely prepared and included data that were more representative over time. These compliance reports were based on data developed from monitoring tools. A database for the monitoring data had been developed which will facilitate analysis and trends.
- The workgroups the Facility had established for continued development of operational plans to achieve SA compliance included the development of a QA component for each provision. The Facility had also developed a set of key indicators it used to measure organizational performance.

Integrated Protections, Services, Treatments and Supports

- The new PSP planning process had been initiated, and most staff had received training.

Integrated Clinical Services

- Psychiatrists had begun to attend PSP planning meetings.
- A speech and language pathologist participated in the PBSP development process.

Minimum Common Elements of Clinical Care

- Collaborative reviews by both psychiatry and psychology took place at psychiatric treatment reviews.

At-Risk Individuals

- The state established a new at risk policy dated 12/29/10 to be effective 1/1/11. DSSLC reported it began implementing the new policy on 1/31/11. The monitoring team had an opportunity to review risk rating assessments

completed under the new policy and believes the new process is much more likely than the old process to accurately reflect risk levels for individuals living at the DSSLC

Psychiatric Care and Services

- The Facility continued to employ three full time staff psychiatrists and one part time contract psychiatrist, all of whom were board certified in psychiatry and all of whom had sufficient experience with intellectual disabilities. The psychiatrists actively and appropriately participated in the interdisciplinary process.
- Psychiatrists at the Facility had heavy clinical caseloads and were very busy, but with the support of the psychiatric assistants and others, they were able to provide the services required by the SA.
- The Facility had recently established a credible process for the development of desensitization plans for identified individuals.
- Reiss screens were administered to all individuals who required them. Psychiatric assessments were completed for all individuals who had psychiatric diagnoses, or who received psychotropic medication.
- New procedures were in place to assure that prior to the administration of psychotropic medications, the PST (including the psychiatrist, Primary Care Physician [PCP] and nurse) considered both the risks of the untreated mental illness and the risks associated with the proposed treatment.
- The Facility had established a psychoactive medication oversight committee, and that committee had started to meet.
- The Facility had established a process for facility-wide monitoring of side effects, in conjunction with the psychoactive medication oversight committee.
- Staff psychiatrists attended neurology clinics, and a process for review and oversight of medications prescribed by both neurology and psychiatry were in place.

Psychological services

- DSSLC continued to display multifaceted efforts toward enhancing the skills and abilities of the Behavior Services staff. The number of Behavior Services staff participating in BCBA classes increased from three to 12. Of particular note was the Psychologist ABA Competence Training. This training was targeted toward new and selected incumbent Behavior Services staff, and was taught by faculty and staff of the University of North Texas.
- Peer review was enhanced by the adoption of a specific rubric for submitted materials with the resulting feedback geared toward enhancing staff competence.
- Competency-based training targeted toward new and selected incumbent Behavior Services staff was implemented.
- New data collection forms that allowed for more diverse measurement strategies were implemented.
- Behavior Services staff had begun the first phase of a strategy to measure interobserver agreement (IOA) for behavior data.
- Progress was noted as well in the assessment of behavior and the development of PBSPs.

Medical Care

- Since the last review for the Settlement Agreement, the Facility's Medical Department has made significant systems improvements, that if further developed and implemented, will help lead the Facility to substantial compliance of Section L.
- Many internal processes have been improved upon. For example, the Annual Assessment form is currently being updated to better reflect clinical practice. A new "transfer physician order" form has been developed and implemented. A "Call a Nurse For" poster was created and is posted throughout the living area, to advise non-clinical staff on important issues that must be well communicated to clinical staff.
- To enhance the ability to efficiently obtain necessary x-rays and echocardiograms, the Facility contracts with a mobile radiology firm that enables remote access to radiologic imagines and reports.
- The Facility has significantly enhanced its ability to conduct mortality reviews.

Nursing Care

- Since the last review the Nursing Department had added three RNs to the 10-6 shift to cover all areas of the campus. There continued to be a decrease in the use of agency nurses.
- Nursing Quality Assurance procedures had improved. Using a peer-to-peer review, monitoring has been done using the newly revised Nursing Monitoring Tools. Data were analyzed for the Facility as a whole but also by living area, which identifies where improvements are most needed.
- Nursing Quality Assurance data were analyzed for the Facility as a whole but also by living area, which identifies where improvements are most needed.
- Significant improvements had been made in promptly assessing individuals with acute illness and injury, notifying physicians, and documentation.
- The Wound Care Nurse and Diabetic Educator Nurse contributed significantly to providing specialized nursing care as did the Hospital Liaison Nurses.
- In March 2011 the Diabetic Educator Nurse began coordination of services and care on a continual basis through the following activities: Coordination of services, daily rounds, monthly summaries, Endocrinology visits with individuals, Diabetic supplies and management and prevention of Diabetic emergencies, and campus-wide Diabetic Education, are most needed.
- Interpretive Guidelines were developed for each of the Nursing Monitoring Tools that identified specific criteria that constituted compliance with each item on the tool as well as ensuring that all monitors are consistent in evaluating data.
- The database for tracking and trending medication errors had recently improved to collect more data from the Medication Error Reports. Medication errors can now not only be tracked by type and category of risk but by unit, shift,

nurse, individual, and probable causes. This depth of information will be valuable in analyzing data to develop individual as well as systemic corrective plans of action.

- The Pharmacy was able to modify the WORx computer system to add on to the Medication Administration Record the number of pills required to equal a total dose. This was a significant improvement and should help reduced medication errors.
- The Pharmacy was also in the process of adding the MAR medications that need to be crushed when individuals were prescribed an alteration in their diet textures. This was a positive finding that will aid in the prevention of individuals choking on medication because the texture was not compatible with their prescribed texture.
- The Acute Illness and Injury Nursing Care Flow Chart developed through a statewide workgroup was impressive and should provide the nurses with a visual cue for decision-making.

Physical and Nutritional Management

- The PNMT meeting attended by the Monitoring Team was impressive in that there was active collaboration between not only all members of the PNMT but the PST as well.
- Information regarding transfers, adaptive equipment, and strategies for oral intake were noted to be clearly written and were supportive in reducing the individuals risk during these activities.
- The PNMT creatively brainstormed and created effective procedures to address the reinventing of positioning standards when utilizing recliners as an alternate option for positioning.

Physical and Occupational Therapy

- An improvement was noted with regards to documentation regarding progress of individuals who were receiving direct OT/PT services. Notes were clearly documented through the use of an initial note, weekly note, and discharge note.

Dental Services

- The Facility had hired an additional full time Dentist, and had posted a position for a much needed additional Dental Assistant.
- The Facility had expanded the use of suction toothbrushes and instituted training for direct care staff of the importance of oral hygiene and preventative measures of aspiration pneumonia.
- A new "Annual Dental Summary" had been developed and implemented. This new form will better inform staff and the PST of oral health care and desensitization needs of the individual.
- The Facility had a clinically viable process to triage and provide emergency dental services. The Monitoring Team reviewed all dental emergencies subsequent to the previous review, noting 20 reported dental emergencies that were effectively managed.

Communication

Habilitation, Training, Education, and Skill Acquisition Programs

Most Integrated Setting

- The Monitoring Team was pleased to see a significant degree of involvement of Contract MRA staff in one PSP meeting during this site visit. There was good interactive discussion between the PST members and the MRA staff, with the former requesting information about community providers, processes, supports and services, and the latter serving an important technical assistance and educational role.
- There had been progress in defining the process, organization and structure of the CLDP meeting,
- PMM Checklists were being completed in a timely manner.
- The Post-Move Monitor had made substantial improvement in the documentation of follow-up for identified deficiencies in the provision of supports, and was to be commended for thoroughness and attention to detail.
- The potential for PMM visits to be missed when the process took place across catchment areas was an area of concern during the site visit in 7/10, but this appeared to have been resolved through a tracking system devised and maintained through DADS state office. In addition, the Facility reported it would only be monitoring individuals placed from DSSLC in the future.

Consent

- The Facility maintained a list of individuals who needed a Legally Authorized Representative (LAR).
- The Human Rights Officers (HROs) had taken some initial steps toward furthering their own education regarding guardianship in preparation for an expanded role in efforts to obtain LARs for individuals lacking LARs. They reported they had attended trainings related to their guardianship responsibilities, including an inservice from the Denton County Probate Court investigator and a training by the local guardianship agency, Health Services of North Texas. This was a positive step towards acquiring the knowledge and expertise needed to assist both individuals and LARs in the guardianship process.

Recordkeeping and General Plan Implementation

- For each individual, the Facility had an active record, a master record, and an individual notebook.
- The process for auditing records had recently expanded to include audits by Records Clerks of records in sister units, with independent inter-rater reliability checks by the Unified Records Coordinator. Emails were sent to staff who were responsible for documents that required corrections, and the URC tracked reports of corrections completed and

checked records to confirm the corrections were in place. A database of corrections needed and made had been implemented to track corrective actions and ensure they were completed. This was an excellent process.

Areas in Need of Improvement: Following is a summary of improvements that continue to be needed.

Restraints

- From document review and interview there is a lack of clarity of work processes and requirements associated with medical restraint. The Monitoring Team was provided with 14 files that were represented to be complete documentation for those 14 instances of medical restraint. There was very little similarity in documentation file to file leaving the Monitoring Team with the impression that DSSLC did not have standardized work processes for the use of medical restraints.
- The Monitoring Team found many instances of incomplete or incorrect documentation of restraint use.

Abuse, Neglect and Incident Management

- There continues to be a problem with timely response from DFPS in initiating investigations. Initial investigatory activity often exceeded the 24 hour requirement, sometimes by days.
- DSSLC needs to modify its Trend Analysis Report to reflect specific data elements on type of allegations and disposition by type not just for the current month but over time, as occurs with some other data elements in the report.
- DSSCLC Procedure: Injury Reporting (5/17/10) does not address the subject of reporting serious injuries to the Facility Director and in fact five of six serious injuries reviewed by the Monitoring Team were not reported timely to the Facility Director/designee.
- Even though staff had received training in abuse/neglect policy and procedure it was apparent key elements of the learning has not been retained.

Quality Assurance

- Data from monitoring by the Facility, particularly observational data, need to accurately reflect performance. Data from observations conducted by the Monitoring Team conducted observations found the engagement level much lower than that reported by the Facility.
- The Facility needs to continue efforts to develop the quality assurance plan, including refining key indicators and outcomes. Review and update the state-created tools so that they are based upon the most recent findings and activities of the Monitoring Teams.
- For some measures, the Facility needs to review data longitudinally over longer time periods in order to identify trends.

Integrated Protections, Services, Treatments and Supports

- Although the structure of an interdisciplinary team is in place at DSSLC, much of the discussion remained multidisciplinary, and decisions about treatment were too often made in the absence of team discussion.

- Many PST members were having difficulty understanding the concept of providing integrated services and the need for a comprehensive PSP that describes the individual's strengths and abilities, and then translating this understanding to a functional and meaningful program of services and supports.
- Staff who were needed because of specific areas of concern or support for individuals was not always present at planning meetings.
- As a way to identify preferences, the Facility had begun to implement the new Personal Focus Assessment (PFA). The goal of this new process was to ensure that individuals' preferences formed the basis for the goals, objectives, anticipated outcomes, services, supports, and treatments of the individual's own PSP. The process was not yet conducted with sufficient quality to reliably identify the individual's strengths, preferences and needs.

Integrated Clinical Services

- Although there has been improvement in participation by more disciplines in the PSP process, there was still a lack of participation by some disciplines, such as Speech and Language Pathology.
- Much involvement in PSP planning remains multidisciplinary.

Minimum Common Elements of Clinical Care

- There had been little progress in performing intellectual and adaptive assessments within appropriate timelines.
- Interventions were not always implemented timely; in some cases, there was not timely assessment conducted to guide development of intervention.
- The Active Problem List used descriptions of psychiatric conditions that did not correspond to the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

At-Risk Individuals

- Risk guidelines provided to QMRPs were based primarily on the history of the indicator occurring and not on indicators that lead to an increased risk. Guidelines need to be expanded to promote proactive review of risk.
- Individuals may be put at unnecessary risk of harm because of extensive use of bedrails and lack of attention to bedrail safety.

Psychiatric Care and Services

- While procedures for medical restraint monitoring in the dental clinic were in place, appropriate procedures had not been established regarding the use of pretreatment sedation for medical procedures.

- Appendix B psychiatric evaluations were used for annual updates. For individuals who did not have adequate evaluations in place, more than an update was needed, and there was a need for more comprehensive reviews/summaries of available records.
- The Facility had not yet provided a process of review and improvement for psychiatric assessments.
- There was much improvement in the area of the appropriate use of psychotropic medications. However, there needed to be greater clarity about the rationale for the use of each medication.
- The Active Problem List (APLs) needed to be updated, to correctly reflect psychiatric diagnoses.
- Behavioral data were considered in decisions regarding pharmacological treatments. However, a process was not in place to provide integrated behavioral care through combined assessment and case formulation.

Psychological services

- Although improvement was noted in PBSPs, they continued to lack sophistication and did not conform to current standards of practice in applied behavior analysis.
- Neither PBSPs nor data graphs reflected the basic conditions necessary to allow for the determination of treatment efficacy.
- In several cases, the strategies for strengthening replacement behaviors were either not implemented by staff or reflected a lack of data.
- Psychological assessment findings were not current, accurate or complete.
- Individuals admitted to the Facility did not routinely receive an intellectual or adaptive assessment at the time of admission regardless of the duration of time since the most recent assessment.
- Although improvement had been made in simplifying the instructions provided to staff regarding behavior interventions, several PBSPs still included complex language likely to hinder staff comprehension.
- DSSLC did not routinely assess the implementation of PBSPs.

Medical Care

- Significant issues continue with the management of chronic and acute medical conditions. Failure to follow-up on clinical conditions, consultation recommendations and abnormal diagnostics, was evident
- The clinical management of orthopedic conditions, diabetes, and especially pulmonary conditions must be immediately enhanced by the Facility.
- Medical and nursing issues must better be reflected at the PSTs and well documented in PSPs and addendums to PSPs.
- The Facility lacks a meaningful medical quality assurance process.

Nursing Care

- The Infection Control Nurse continued to track infectious and communicable diseases. However, the Infection Control Nurses could benefit from technical assistance to improve the analysis and trending of infection control data. The responsibilities of the Infection Control Program are comprehensive and multifaceted, particularly in a facility as large as DSSLC.
- The Nursing Department has made improvements in the Comprehensive Nursing Assessments through additional training and monitoring but still has an opportunity for continuing improvement. The greatest challenge for the Nurse Case Managers is the ability to analyze raw clinical data and to apply in making clinical decisions to evaluate individuals' health status and for future planning purposes.
- The Nursing Department continued to use the Health Care Protocols for Developmental Disability Nurses. While these protocols serve as good reference they should only be used as a guide in developing health care plans. Health Maintenance Plans and Acute Care Plans need to be individualized to meet the unique needs of individual health care conditions.

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

- The Facility must enhance its policies to reflect the actual process for monitoring new medication orders, roles and responsibility of staff, documentation practice, and remedial action.
- The Facility must ensure that the pharmacist documents appropriate rationale and follow-up issues related to each intervention.
- Quarterly drug regimen reviews lack comprehensiveness.
- The Facility did not specifically monitor for metabolic syndrome; did not specifically monitor the use of benzodiazepines and anticholinergic medications, or maintain a specific database for trends analysis of their use; and did not demonstrate a trends analysis for the use of STAT medications.
- Physicians continue to use the terms "will continue to monitor" and "the benefits outweigh risks" without providing appropriate clinical rationale.
- The Facility must immediately address its process on identifying, assessing and following up on adverse drug reactions.
- The various responsibilities for the medication variance process were fragmented, physician staff were not involved, there was a lack of comprehensive data collection for the medication variance program, no formal policies for a comprehensive medication variance program existed, and there was a lack of formal policy and process on providing remedial action for medication variances.

<u>Physical and Nutritional Management</u>

- Although a Physical and Nutritional Management Team (PNMT) had been formed as well as a Physical and Nutritional Management committee (PNMC), a process that outlines the responsibilities of both teams as well as their scope had not yet been developed.

- There was still no evidence that data are collected and the team is reviewing these data to better identify system issues or respond to recurrent issues on a regular basis.
- A new risk policy and procedure was in the process of being implemented to address the need to more accurately identify an individual's risk. While this new process was much improved and risk level was accurately identified for more people, the risk process was not consistently implemented correctly.
- Individuals were not provided with a comprehensive assessment by the PNM team or PST that focused on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake.
- Supports regarding the areas of oral care and medication administration were not comprehensive and lacked detail on the PNMP.
- Staff was observed not implementing PNMPs and displaying safe practices that minimize the risk of PNM decline. Staff 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.
- There was not a formal monitoring process in place that clearly defined how the monitoring process would be maintained or implemented.
- An Aspiration Pneumonia/enteral Nutrition evaluation was developed which was a positive step. However, the evaluation is completed as more of a review and does not investigate root cause of the issue resulting in hospitalization. Additionally, pathways to PO (by mouth) status and the implementation of oral motor strategies to improve oral control and maintenance were consistently not implemented or identified.

<u>Physical and Occupational Therapy</u>

- 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.
- Individuals not receiving direct services were not consistently reviewed by OT/PT should there be a change in status,
- 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.

<u>Dental Services</u>

- There was no effective means to maintain data specific to dental issues, nor to maintain a comprehensive, real-time, dental schedule. All data and scheduling were compiled manually, which resulted in system failures.

- The Facility was delinquent in providing dental services such as restorative treatments, and x-rays. This issue is reported to be secondary to not having necessary dental staff and to scheduling issues. The Facility must immediately implement enhanced measures to ensure that individuals are provided timely dental services, when clinically appropriate.
- Oral health care needs must be better incorporated into the PST process. The PST must fully understand the individual's oral health care issues; monitor progress; review the use of sedation, restraint and desensitization programs; and ensure that services are provided promptly. Such issues and efforts must be well documented in the PSP.
- Despite recent improvements with providing oral care at the living area, this process must be immediately enhanced to ensure that all individuals at the Facility realize the benefits of quality oral care on a daily basis.
- Efforts to establish a meaningful desensitization program continue, albeit at a slow rate. A desensitization program must be fully implemented as soon as possible.

Communication

- DSSLC only has 2.5 SLPs on campus.
- 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.
- AAC devices are not consistently portable and functional in a variety of settings. DCPs interviewed were not knowledgeable of the communication programs. Plans are not implemented secondary to excessive delays in the acquisition of devices or devices being broken or missing.
- DSSLC had a monitoring form that tracked the presence and working condition of the AAC equipment; however, implementation was not consistent due to lack of available staff.

Habilitation, Training, Education, and Skill Acquisition Programs

- Skill acquisition programs continued to lack essential components and formal teaching was encountered only sporadically.
- Assessments required for the PSP were frequently not submitted to the appropriate location or not submitted at all.
- Community outings reflected a declining trend over several months and staff reported that skill acquisition programs are not typically implemented in the community.

Most Integrated Setting

- The Facility continues 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 had done little during this monitoring period to provide education and promote awareness of community living options, providing documentation of only eleven individuals and 18 staff participating in community tours for a four month period.
- While the Community Placement Report indicated that there were no individuals included in that category, the Facility reported elsewhere in the document request that there were individuals who had requested community living, but were not referred due to LAR choice.

Consent

- The Facility reported it was awaiting final guidance from DADS State Office on development of statewide policies, procedures and practices that will provide guidance prior to implementing significant changes.
- The Facility did maintain a list of individuals needing an LAR, but there was still no standardized approach to assessing and determining the actual need for an LAR on an individualized basis that was consistent with commonly accepted professional standards of practice.
- Only five guardians had been obtained, and several of these were successor guardians for individuals who had previously been adjudicated as in need of an LAR.

Recordkeeping and General Plan Implementation

- In addition to the unified record, the Facility had a share drive that allows sharing of assessments so they are available to all clinicians and the QMRP on an individual's PST. Because many assessments were not posted to the drive timely, this system was not as useful as it could be.
- The Facility did not have a process in place to monitor and evaluate how records are used. Through interviews and review of documents, the Monitoring Team found indications that staff used the information in records as they were considering supports and services but also that materials were missing or misfiled, or were filed and posted too late to be used for decisions.
- The Facility had developed or revised a large number of policies since the last compliance visit. This active development of policies is commendable. Nevertheless, there are other policies that must be developed.

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) 3/15/11 3. Settlement Agreement (SA) Section C Presentation Book (undated) 4. DSSLC Policy CMGMT-20 Limitation of Restraint as a Crisis Intervention dated 11/05/09 5. DSSLC Policy CMGMT-21 Dental/Medical Sedation and Restraint dated 11/05/09 6. PMAB Training Curriculum (undated) 7. Training Curriculum for RES0105 (Restraint: Prevention and Rules for Use at MR Facilities) and RES0110 (Applying Restraint Devices) undated 8. Sample of staff training records 9. Sign-in sheet for training conducted 1/13/11 labeled "Restraint Monitoring Training" 10. Restraint files for sample of crisis intervention restraints including Restraint Checklist, Face-to-Face Assessment/Debriefing (FFAD), restraint review documentation, Positive Behavior Support Plan (PBSP), Safety Plan for Crisis Intervention (SPCI) and Personal Support Plan Addendums (PSPAs) for Individuals #127 (restraints 1/21/11 2x, 2/1/11 5x, and 2/20/11), #624 (restraints 1/26/11, 2/6/11 2x, 2/20/11, and 3/10/11), #12 (restraints 1/24/11 2x and 1/25/11), #50 (restraint 2/2/11), #483 (restraint 2/19/11), #720 (restraint 2/23/11), #537 (restraint 1/30/11, #669 (restraint 2/26/11, # 110 (restraint 3/1/11), #653 (restraint 3/11/11, and #624 (restraint 3/12/11) 11. Restraint files for sample of protective mechanical medical restraint for Individuals #445 (10/27/10), #359 11/10/10), #578 (12/30/10 2x), #87 (1/5/11), and #506 (2/16/11) 12. Restraint files for sample of pretreatment sedation medical restraint for medical procedures for Individuals #786 (9/3/10), #278 (9/1/10), #228 (9/24/10), #269 (10/27/10, #414 (11/1/10), #540 (11/19/10, #183 (12/1/10), #590 (12/2/10), #583 (12/1/10), #312 (1/25/11), #367 (1/28/11), #723 (2/15/11), #237 (3/25/11), #585 (3/17/11), # 572 (3/14/11), #279 (2/28/11), #139 (2/25/11), # 417 (2/25/11), #163 (2/24/11), #469 (2/15/11), #161 (2/16/11), #248 (2/15/11), #762 (2/15/11), #630 (2/16/11), and #664 (2/23/11) 13. Restraint log for physical restraint 9/1/10 to 3/15/11 14. Restraint log for protective restraint 10/1/10 to 3/29/11 15. Restraint log for chemical restraint 9/1/10 to 3/15/11 16. Restraint log for emergency mechanical restraint 9/1/10 to 3/15/11 17. Restraint log for restraints which occurred off campus 2/8/10 to 2/8/11 18. Clinical Justification and related information for extraordinary circumstances for SPCI for individuals #337 and #381. 19. Draft Guidelines for Determination of Need for Dental Desensitization (undated) 20. Staff Injuries During Restraint 3/1/10 to 2/28/11 21. List of individuals injured while under restraint 3/1/10 to 2/28/11

	22. List of individuals with a Safety Plan for Crisis Intervention (SPCI) 23. List of Individuals with a desensitization plan and sample plans 24. Restraint Trend Analysis report for March, 2011 25. SA Compliance Report Section C – 1/31/11 26. Restraint monitoring audit tool and related Plan of Improvement template (undated) 27. Restraint Reduction Committee minutes 10/29/10, 11/30/10, 12/22/10, 1/26/11, and 2/25/11 28. Incident Management Review Team (IMRT) Meeting minutes for 1/3/11, 1/10/11, 1/18/11, 1/24/11, 1/31/11, 2/7/11, 2/14/11, 2/22/11, 2/28/11, 3/7/11, and 3/28/11 29. DADS Report MHMR0102 Percent of All Employees Completing Courses of Training Program 3/1/11 **People Interviewed:** 1. Jill Wooten, BCBA 2. Randy Spence, Director of Behavioral Services 3. Lori Powell, Director of Quality Assurance 4. Ken Horstman, Director of Residential Services 5. Frank Padia, Director of Program Coordination 6. Deb Salsman, Director of Incident Management 7. Sheila Carpenter, SA Coordinator 8. Dora Tillis, Assistant Director of Programs 9. Elaine Davis. Director of Training and Development 10. Dr. Michael Cousins, Dentist 11. Cynthia Murrell, Dental Hygienist 12. Sibylle Graveitt, RN Case Manager Supervisor and Delia Schilder RN, CDDN, CNE 13. Ten Direct Care Professionals (DCPs) **Meetings Attended/Observations:** 1. Incident Management Team (IMRT) 3/28/11 2. Restraint Reduction Committee 3/30/11 3. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 3/31/11
	Facility Self-Assessment: The DSSLC's Plan of Improvement (POI) reported that Provision C.1 and C.3 were in substantial compliance with the Settlement Agreement. The Monitoring Team did not find sufficient evidence to determine substantial compliance with these provisions. The DSSLC POI reported it had not yet achieved compliance with the other provisions of Section C of the SA and the Monitoring Team concurs. Implementation of medical restraint, particularly pre-treatment sedation is problematic at DSSLC. The Monitoring Team was unable to develop a clear understanding of work process expectations due to unclear policies and inconsistent responses to questions posed by the Monitoring Team to various DSSLC administrative staff. For example, different administrators provided three different answers when asked "where in the record would I find documentation regarding medical restraint." The knowledge of Direct Care Professionals in restraint policy and application was insufficient and additional training is needed.

	Properly documenting restraint use on the Restraint Checklist and Face-to-Face Assessment/Debriefing forms needs to improve.
	Summary of Monitor's Assessment: The DSSLC's Plan of Improvement (POI) reported that Provision C.1 and C.3 were in substantial compliance with the Settlement Agreement. The Monitoring Team did not find sufficient evidence to determine substantial compliance. The DSSLC POI reported it had not yet achieved compliance with the other provisions of Section C of the SA and the Monitoring Team concurs. Crisis intervention restraint use at DSSLC was trending down. The two individuals with special circumstances who are restrained experienced a reduction in restraint use of 18% in the three month period preceding the site review (December 2010, January and February, 2011). The number of crisis intervention restraints for other individuals living at the DSSLC also decreased. In the three month period preceding the site review (December 2010, January and February, 2011) crisis intervention restraint use decreased by 39% when compared with the prior nine months. There was only one instance of use of chemical restraint since the last review. From document review and interview there is a lack of clarity of work processes and requirements associated with medical restraint. The Monitoring Team was provided with 14 files that were represented to be complete documentation for those 14 instances of medical restraint. There was very little similarity in documentation file to file leaving the Monitoring Team with the impression that DSSLC did not have standardized work processes for the use of medical restraints. In addition, there did not appear to be any standard methodology for the filing of medical restraint information in the record. Upon interview, three different administrators provided three different answers when asked "where in the record would I find documentation regarding medical restraint." The Monitoring Team found many instances of incomplete or incorrect documentation of restraint use. Additional staff training is needed. The Facility had a process to audit restraint records and provide on-the-spot training to staff. This should lead to improved compliance. The knowledge of Direct Care Professionals in restraint policy and application was insufficient and additional training is needed. The Facility's Restraint Reduction Committee had become more active and meeting content appears to be substantive, including case presentations for roundtable discussion.

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C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately	In its Plan of Improvement (POI) the DSSLC reported that it was in substantial compliance with this provision of the Settlement Agreement (SA). The Monitoring Team does not concur.	Noncompliance

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	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.	DSSLC Limitation of Restraint as a Crisis Intervention policy (CMGMT-20 - 11/5/09) and DSSLC Dental/Medical Sedation and Restraint policy (CMGT-21 – 11/5/09) guide facility practices with respect to restraint use. DSSLC Limitation of Restraint as a Crisis Intervention policy (CMGMT-20) is comprehensive and directs itself to the practices necessary to achieve compliance with the Settlement Agreement. From review of documentation it is apparent that the procedures and documentation called for in the policy are for the most part understood by staff at the facility and efforts to comply with the policy occur. Nevertheless, the Monitoring Team did identify numerous examples of documentation errors. DSSLC Dental/Medical Sedation and Restraint Policy (CMGMT-21 – 11/5/09) also directs itself at compliance with the requirements of the SA. Documentation review and interviews by the Monitoring Team suggests that staff who should understand this policy, primarily medical and nursing staff, do not, or if they do they do not consistently use the procedures in the policy correctly. For example, this policy clearly states that for medical/dental restraint "the use of restraints is recorded on the Restraint Checklist." In its review of medical/dental restraint documentation the Monitoring Team found a Restraint Checklist in only eight of 29 (28%) medical restraints reviewed. A sample of crisis intervention restraint episodes, referred to as Sample C.1, was selected. The source document used for the sample was the listing of restraints used in the last six months provided in response to the monitoring team's pre-visit document request. The sample included 10 individuals and 25 restraint episodes, representing 20% of restraint records over the last six-month period. This sample was selected to ensure that some of the individuals with the highest numbers of restraint were included. The individuals in this sample included: Individuals #12, #50, #110, #127, #483, #537, #624, #653, #669, and #720. A separate sample was selected for medical restraints. Four of the individuals in the sample had Safety Plans for Crisis Intervention (SPCI) and six did not. To assist in the review of restraint documentation the Monitoring Team asked that the facility prepare a file for each restraint episode selected for the above sample. This was to include the Restraint Checklist, Face-to-Face Assessment/Debriefing, any medical orders, any physician specified monitoring schedule, any standard facility protocol for monitoring restraint, documentation of review activity, and any other information that might be helpful in understanding the circumstances associated with the restraint use such as the individual's Positive Behavior Support Plan. For the most part the only information contained in the restraint files provided to the Monitoring Team were the Restraint Checklist and Face-to-Face Assessment/Debriefing form. Working with these limited data the Monitoring Team was unable to consistently validate work activity	

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		associated with several key SA requirements, for example, the review activity, including PST review, associated with each specific restraint episode in the sample. Two individuals (#337 and #381) were not included in this sample of restraints even though they were restrained frequently using protective mechanical restraints to prevent self-injury. These individuals present unique clinical challenges which are reported in other sections of this report. The facility had a SPCI and a "Clinical Justification for Extraordinary Circumstances", approved by the Facility Director and attending physician, in place for each individual. The facility's clinical interventions had resulted in an 18% decrease in the frequency of use of protective mechanical restraint in a three month period (December, 2010 to February, 2011) when compared to the prior nine months. These two individuals were restrained an average of 104 times during this three month period compared to 126 times per month the prior nine month period. The Monitoring Team reviewed the SPCIs and determined they were being implemented as written and that the provisions for monitoring in the clinical justification document were being followed. In each case psychiatric treatment records were reviewed, including psychiatric assessments, PTRs, and related PBSPs. Individual #337 was diagnosed with a developmental disability that has a behavioral phenotype that includes compulsive self-injury. The individual was also diagnosed with a generalized anxiety disorder. The individual had several psychotropic medication trials over the years. These included a variety of antipsychotics. At the time of the tour the individual was currently treated with an anxiolytic, and with an anticonvulsant for both epilepsy and mood stabilization. The records did not mention whether there was a trial with an opiate antagonist. Psychiatric tracking was active. Measures included agitation and crying in certain situations. PTR notes suggested that the current psychotropic treatment reduced the symptoms of anxiety. Individual #381 was not under psychiatric care and had not had any psychiatric involvement in recent years. The Monitoring Team suggests that the facility provide a psychiatric consultation for individual #381, to assess whether psychiatric treatment might reduce the use of restraints. <u>Prone Restraint</u> Based on Facility policy review, prone restraint is prohibited. Based on review of restraint records, restraint reduction committee minutes, and minutes of the Incident Management Team (IMRT), no clear use of prone restraint was identified or the subject of any discussion in meeting minutes. Nevertheless, six of the 10 individuals in the crisis intervention restraint sample were involved in side-lying restraint which can result in the	

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		individual being in a prone position even if only for a brief moment. Most DCPs interviewed did not know what prone restraint was. Only two responded correctly when asked "do you know what prone restraint is." When it was described by the Monitoring Team seven of the remaining eight staff interviewed knew it was prohibited. One staff person never acknowledged that prone restraint was prohibited. This suggests a need for additional training to ensure implementation of side-lying restraint techniques do not inadvertently include the individual being in a prone position during any phase of the restraint implementation. Based on an interview of 10 staff responsible for the provision of supports to individuals, two were aware of the prohibition on prone restraint. Seven of other eight did not know what prone restraint was but when prompted by the monitoring team responded by indicating "we don't do that here." One staff person never acknowledged that prone restraint was prohibited. <u>Other Restraint Requirements</u> Based on document review, the Facility policies state 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. Restraint records were reviewed for Sample C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: 1. In 18 of the 25 records (72%), there was documentation showing that the individual posed an immediate and serious threat to self or others. The FFAs showed 100% compliance but only by a check in a box on the form. This is not sufficient to demonstrate compliance. In at least seven instances the information on the Restraint Checklist was insufficient to determine compliance. For example, for Individual #12 the only information provided was the individual wanted to go on a van ride and was still upset with something that happened earlier in the day. There was no description of what the individual was actually doing that posed an immediate and serious threat. For Individual #537, the only information provided was he wanted to play his video game. There was no description of what the individual was actually doing that posed an immediate and serious threat. For Individual #127 the Restraint Checklist reported "became aggressive to staff". This statement alone does not validate immediate and serious threat. For Individual #127 (different restraint episode) the only information provided on the Restraint Checklist was "another resident broke a	

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		personal item." There was no description of what the individual was actually doing that posed an immediate and serious threat. 2. For 25 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 25 (100%) contained documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. This documentation consisted of the appropriate response being marked on the FFAD. Nothing else on the FFAD or Restraint Checklist would clearly indicate that restraint was used for the convenience of staff or not in a clinically justifiable manner. It is always possible, absent more specific documentation, that restraint may on occasion be used for the convenience of staff or not in a clinically justifiable manner. This could occur when a Positive Behavior Support Plan (PBSP) has not been effective and needed changes are not being addressed in a timely manner. As reported in section J the DSSLC has made improvements in its overall approach to behavioral programming that move it in the direction of SA compliance. Many of these changes are recent and have not as yet had facility wide impact. 3. Of concern to the Monitoring Team is the degree to which direct care professionals have been adequately trained in restraint policies and implementation of those policies. Direct care professionals interviewed during this review were not sufficiently knowledgeable of basic restraint policy. The direct care professionals chosen for interviews had all been involved in restraint application within the prior 90 days. Only four (40%) provided good descriptive information of restraint policy and procedure and of specific interventions that can be attempted to avoid the use of restraint. Others were only able to provide relevant information after significant prompting by the Monitoring Team. 4. In 20 of 25 restraint records (80%), there was documentation that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. In none of the five restraints of Individual #127 was there any indication that pre-restraint intervention included implementation of interventions in the PBSP or SPCI. Examples where restraint documentation provided sufficient information regarding whether a graduated range of less restrictive measures was used included: • Several restraint checklists indicated in narrative form the actions taken to try to avoid restraint. This was the case with Individual #624 (restraints 1/26/11 and 3/12/11). Others indicated use of a number of pre-restraint interventions. The Restraint Checklist for Individual #624(2/6/11) included interventions in Safety Plan, verbal prompt, redirection, and traded out staff. Individual #669 (2/26/11) included prompted replacement behavior, prompted coping skills, redirection,	

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		moved others away, traded out staff, moved furniture, changed environment, and removed dangerous object. • Six restraint checklists only indicated verbal prompt and redirection as interventions attempted pre restraint. Some examples include were Individual #720(2/23/11) and Individual #127 (1/21/11 3x, 2/1/11, and 2/20/11). In these cases the Monitoring Team is concerned that staff are sufficiently trained and knowledgeable of the full range of interventions that may be appropriate for each specific individual, particularly with Individual #127 whose PBSP and SPCI contained specific interventions. In none of the five restraints of Individual #127 was there any indication that pre-restraint intervention included implementation of interventions in the PBSP or SPCI. The Monitoring Team conducted an in-depth psychiatric review of two individuals who were frequently restrained. Individual #624 was restrained more than three times per month in September 2010 and in each of the following four months, for a total of 38 episodes of restraint over the course of five months. The Monitoring Team requested documentation of the reviews that were required when more than three episodes of restraint occurred during a 30 day period, but the Facility was unable to locate any documentation for the meetings. Restraint checklists, face to face assessments debriefings, and administrative/clinical reviews for crisis intervention restraint, were provided to the Monitoring Team for a number of the episodes of restraint. The restraint debriefings indicated that staff members were familiar with the safety plan that was in place for the individual, and the steps that were taken were consistent with the plan. The psychiatric assessment for the individual was reviewed. It identified diagnoses of bipolar disorder, attention deficit hyperactivity disorder, and a sexual disorder. The individual was followed in the psychiatric clinic, and at the time of the visit the individual was prescribed psychotropic medications. The Monitoring Team found the psychiatric care to be appropriate. Individual #127 was restrained four times in October 2010, six times in November 2010, and seven times in January 2011. Restraint checklists and face-to- face debriefing forms for crisis intervention were reviewed for many of these episodes of restraint. PSP addenda for review of the three or more restraints in any 30 day period were held on 11/02/10, 01/20/11 and 01/21/11. Each of these reviews was attended by the QMRP, the Psychologist and the RN Case Manager. On two occasions, a Direct Care Professional also attended. During the PSP addendum meeting held in January 2011 (but not the PSP addendum meeting of November 2010), the format of the review followed an outline that followed items a-h of provision C7. The entries on the addendum did not reflect substantive consideration of many items. For example, on the 01/20/11 addendum the review of biological/medical risk factors was assessed as “N/A” and for “trends” related	

#	Provision	Assessment of Status	Compliance
		to the restraint use, the review stated that "the individual cycles bi-monthly. When cycling, restraints are used three of more time during his cycle to prevent injury to himself, his peers and staff." In contrast, PTR notes indicated that during the period in question the psychiatric team had been actively monitoring the individual's status in PTR meetings, had met frequently during periods of increased difficulty for the individual. On 11/10/10 the psychiatrist made medication changes that were assessed on 11/23/10 to have been helpful in re-establishing some clinical stability for the individual. Thus, the psychiatric notes reflected active – and somewhat effective - treatment efforts, at a time that the PSP addendums reflected static clinical circumstances that required intermittent use of restraints whenever the individual "cycled." The monitoring team recommends that a member of each of the relevant clinical disciplines should participate in reviews of frequent use of restraints to assure active discussion of efforts to minimize the use of restraints. Facility policies identify a list of approved restraints. Based on the review of 25 restraints, involving 10 individuals, 25 (100%) were approved restraints. The monitoring team is concerned with staff knowledge of restraint policies and procedures, as described earlier in this section.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. The restraint records involving the 10 individuals in Sample C.1 were reviewed. Of these, four of the individuals (40%) had Safety Plans that described the circumstances for the use of restraint, including release criterion. For the four individuals who had Safety Plans, one (25%) included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Safety Plan. Examples where documentation showed that restraint release was not in accord with the Safety Plan specifications include: 1. Five restraint episodes were reviewed for Individual #127. The Safety Plan called for release "as soon as he is calm." Being calm, and therefore able to be released from restraint as per Safety Plan specification, is different than "no longer being an immediate and serious risk of harm to self or others". Presumably being calm would require a time interval between when a person is no longer an immediate and serious risk of harm to self or others and when that person reaches a state of being calm. The release code on the restraint checklist for Individual #127 for restraint on 2/1/11 and 1/21/11 was L which is	Noncompliance

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		"released immediately when no longer immediate and serious risk of harm to self or others." The safety plan called for the individual to be released "as soon as he is calm. " The appropriate code on the restraint checklist would be J – Met Safety Plan calm criteria and released. It is not possible from the information on the restraint checklist, or the accompanying FFAD, to determine if the individual was released from restraint using the criteria set forth in the SPCI. 2. An identical scenario was presented in the restraint documentation for Individual #50 (2/2/11) and Individual #537 (1/30/11). Individual #624 also had a Safety Plan that specified release criteria of "as soon as he is calm." For this individual the restraint checklist indicates release from restraint appropriately using code J for restraint episodes on 2/6/11, 2/20/11, and 3/12/11. However, the concern with the release criteria remains. An individual may no longer be a danger to self or others even though the individual is not calm. For the six individuals who did not have Safety Plans, all (100%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself. Examples showing documentation that the individual was released when he/she was no longer a danger to self or others included: 1. For Individual #12 (1/24/11) the Restraint Checklist indicated release code L – "released immediately because no longer an immediate and serious risk of harm to self/others." 2. For Individual #653 (3/11/11) the Restraint Checklist indicated release code L – "released immediately because no longer an immediate and serious risk of harm to self/others."	
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	In its Plan of Improvement (POI) the DSSLC reported that it was in substantial compliance with this provision of the Settlement Agreement. The Monitoring Team does not concur. The Facility's policies related to restraint are discussed, in part, in Section C.1. DSSLC Limitation of Restraint as a Crisis Intervention policy (CMGMT-20 - 11/5/09) and DSSLC Dental/Medical Sedation and Restraint policy (CMGT-21 – 11/5/09) guide facility practices with respect to restraint use. DSSLC Limitation of Restraint as a Crisis Intervention policy (CMGMT-20) is comprehensive and directs itself at the practices necessary to achieve compliance with the Settlement Agreement. DSSLC Dental/Medical Sedation and Restraint Policy (CMGMT-21 – 11/5/09) also directs itself at compliance with the requirements of the SA. Review of the Facility's training curricula revealed that it included adequate training and	Noncompliance

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	applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	competency-based measures in the following areas: 1. Policies governing the use of restraint; 2. Approved verbal and redirection techniques; 3. Approved restraint techniques; and 4. Adequate supervision of any individual in restraint. DSSLC Limitation of Restraint as a Crisis Intervention policy (CMGMT-20 - 11/5/09) does not include specific classes, by reference number, required of staff. In the absence of policy defined required training, the Monitoring Team checked 21 staff training records (selected by picking the last name on the bottom of each printout page of the list of employees) to validate completion of the following courses: 1. RES0105 Restraint: Prevention and Rules for Use at MR Facilities 2. RES0110 Applying Restraint Devices 3. PMA0320 – PMAB Basic 4. PMA0400- PMAB Restraint 5. PMA0700 –PMAB Prevention 6. PBS0100 – Positive Behavior Support The Monitoring Team identified a sample of 21 direct care staff, referred throughout the report as Sample C.2. The 21 staff in the sample all completed, within the last 12 months, RES0105, PMA0320, PMA0400, PMA0700, and PBS0100. Twenty of the 21 (95%) completed RES0110. The Monitoring Team also reviewed a State report "Percent of All Employees Completing Courses of Training Program." This report indicated the following completion rates for DSSLC employees: 1. 97% RES0105 Restraint: Prevention and Rules for Use at MR Facilities 2. 96% RES0110 Applying Restraint Devices 3. 96% PMA0320 – PMAB Basic 4. 96% PMA0400- PMAB Restraint 5. 96% PMA0700 –PMAB Prevention 6. 96% PBS0100 – Positive Behavior Support When documentation has errors and does not demonstrate for all restraints that policy was followed (as noted in Provision C1), another way to determine whether training on policies has been competency-based and whether staff remain competent is to determine whether they can explain the policies. Based on an interview of 10 staff responsible for the provision of supports to individuals, in which they were asked to tell the Monitoring Team about the policies covering restraint: 1. Four (40%)were able to adequately describe policies governing the use of restraint	

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		2. Eight (80%) were able to adequately describe approved verbal and redirection techniques 3. Three (30%) were able to adequately describe approved restraint techniques 4. Two (20%).were able to adequately describe adequate supervision of any individual in restraint. Staffs' inability to clearly and accurately describe some of the fundamental restraint policy requirements may indicate a need for further training to ensure competent implementation of restraint procedures. All 10 staff interviewed had been directly involved in using restraints within the last three months. The Monitoring Team was able to solicit better responses after asking leading follow-up questions. Because these staff had recently been involved in restraint application the Monitoring Team expected clearer articulation to straightforward questions and remain concerned that staff did not have a thorough understanding of the policy regarding use of restraint (and thus could violate that policy inadvertently). As noted in Section C.1 80% of the restraint records reviewed showed that restraint was only used after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	
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.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. The DSSLC Limitation of Restraint as a Crisis Intervention policy (CMGMT-20) states that restraint can only be used for crisis intervention. Based on a review of 25 non-medical (crisis intervention) restraint records (Sample C.1), in 24 (96%) there was evidence documenting that restraint was used as a crisis intervention. On the restraint checklist for Individual #127 (1/21/11) the type of restraint section was not completed. The FFAD suggested the restraint was a crisis intervention but it was not documented as such on the restraint checklist. The Restraint Checklist is considered by the Monitoring Team to be a primary source of restraint documentation. It is imperative it be complete and accurate. Documentation provided by the Facility relevant to the 25 non-medical (crisis intervention) restraint records reviewed did not contain information about whether a physician had provided a medical order stating whether the individual could or could not be restrained, or if there were limitations on the type of restraint that could be used. Therefore, the Monitoring Team could not determine whether any restraints used were prohibited by medical orders. The Monitoring Team had asked that the Facility prepare a	Noncompliance

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		file for each restraint episode selected for the sampled restraint episodes. This was to include the Restraint Checklist, Face-to-Face Assessment/Debriefing, any medical orders, any physician specified monitoring schedule, any standard facility protocol for monitoring restraint, documentation of review activity, and any other information that might be helpful in understanding the circumstances associated with the restraint use such as the individuals Behavior Support Plan. The absence of some relevant documentation in the files prepared by the DSSLC does not allow the Monitoring Team to adequately assess this requirement. Physician orders for crisis intervention restraint which is not part of a SPCI are required by State policy. Eight of the 25 restraints in Sample C.1 involved individuals without a SPCI. Physician orders were provided to the Monitoring Team in three instances (38%). These were for Individual's #653 (3/11/11), #110 (3/3/11), and #669 (2/26/11). Physician orders were not provided for Individual's #12 (1/24/110 2x and 1/25/11), # 483 (2/19/11), and #720 (2/23/11). <u>Medical Restraints and Pre-Treatment Sedation for Routine Care</u> The Monitoring Team reviewed medical monitoring of oral pre-treatment sedation related to medical procedures, for individuals #183 (12/01/10), #228 (09/24/10), #269 (10/27/10), # 278 (09/01/10), #312(01/20/11), #367 (01/28/11), #414 (11/01/10), #472 (11/30/10), #540 (11/29/10 and 12/17/10), #583 (12/02/10), #590 (12/02/10), # 664 #723 (12/02/10), and #782 (09/03/10). Clinical materials reviewed included documentation associated with medical restraints such as restraint checklists, face-to-face assessment & debriefing documents, medical orders, physician specified monitoring schedule, documentation of review activity, any other documentation associated with the restraint use, and integrated progress notes The Monitoring Team also reviewed medical monitoring during intravenous (IV) sedation related to dental procedures, for individuals #217 (09/01/10), # 244 (09/29/10), #270 (09/01/10), and # 429 (09/29/10). Clinical materials reviewed included documentation associated with IV dental sedation on specified dates, including restraint checklist/face-to-face assessment & debriefing documents, medical orders, physician specified monitoring schedule, the standard facility protocol for monitoring medical restraint, and any other information associated with the restraint use. The Monitoring Team reviewed PSP information regarding development and/or implementation of plans to minimize use of medical restraint for the individual (including data sheets if a program was developed and implemented) for all eighteen individuals cited above. The Monitoring Team met with Sibylle Graveitt, RN Case Manager Supervisor and Delia Schilder RN, CDDN, CNE. and reviewed how safety monitoring was provided when oral pre-treatment sedation and IV sedation were used during medical and dental procedures.	

#	Provision	Assessment of Status	Compliance
		Ms. Schilder and Ms. Graveitt informed the team that when IV sedation was used, nurses accompanied individuals from the residence to the dental clinic and monitored the individual for safety with the Sedation Checklist. Vital signs were obtained per guidelines of the medical restraint guidelines, and monitoring continued in the infirmary, at least until a score of 8 was recorded on the REACT form (a measure of level of sedation, on which higher scores indicated less sedation). Restraint Checklists were not used for IV dental procedures as required by DSSLC policy. Ms. Schilder and Ms. Graveitt reviewed procedures used when pre-treatment sedation was used for medical procedures. During on-campus procedures, the DSSLC outpatient medical consultation procedure form was typically used. Per information reported by the Facility to the Monitoring Team, there had been no use of oral pre-treatment sedation in the dental clinic during the six months period of September 2010 and February 2011. The Monitoring Team reviewed intravenous dental sedation (TIVA) monitoring, as follows: Between September 2010 and February 2011 individuals received dental examination under IV sedation 47 times. The monthly frequencies varied from a low of four in January to a high of 11 in November. The monthly average was 7.83 times. The Monitoring Team reviewed each of the 4 cases of IV sedation, individuals #217 (09/01/10), # 244 (09/29/10), #270 (09/01/10), and # 429 (09/29/10). In each case the procedure was an annual examination. In three of the four cases, (all except #217) pre/active/post sedation checklists were used. Vital signs were obtained prior to the procedure, and 15 minute vital signs were done after the procedure was complete. In all cases a REACT score of at least 8 was documented in the infirmary area. The REACT score was documented in the narrative notes (medical and dental) which were part of the sedation checklist. Documentation was provided during the procedure via the anesthesiology notes. The routine at instructions provided upon completion of the procedure included dismissal from the infirmary when the patient was alert and oriented and for the individual to rest the home for 24 hours. In the fourth case (# 217) dental progress notes documented IV sedation for the annual exam, but no other documentation was available. For individuals # 244, # 270, and #429, documentation was also provided from the integrated progress notes which showed nursing follow-up on the home during the 24 hours. One case (Individual #429) contained a note from the day after the procedure that enhanced supervision could be discontinued. In a second (Individual #270) there was nursing follow-up on the unit (without vital signs) on the same day, and two days later, with vital signs. In a third case (Individual #244), nursing follow-up was provided on the home the same evening with vital signs, and twice in the following 24 hours. In one case, (individual #429) the restraint checklist was completed; on that form vital signs were not reported but the form clarified that these were reported on the sedation checklist. DSSLC informed the Monitoring Team that between September 2010 and February 2011	

#	Provision	Assessment of Status	Compliance
		medical pretreatment sedation was used 135 times (the monthly high was 38 uses in December 2010 and the monthly low was 16 in November monthly average was 22.5). While on site, the Monitoring Team requested and reviewed 14 cases of medical pretreatment sedation. These represented eye examinations (5), imaging studies (4), a gynecological exam, a bone scan, a case of suture removal, an echocardiogram, and a bone density and mammography (1 of each). In five of the cases, baseline vital signs were located in either the integrated progress notes or on a consultation form. In eight cases, a REACT form for level of sedation after the procedure was located. In three cases the sedation checklist was completed (all were off-campus procedures). The DSSLC outpatient medical consultation form was completed for seven individuals. Restraint Checklists were not used for these procedures as required by DSSLC policy. The Monitoring Team met with Ms. Jill Wooten, BCBA, to review procedures in place to establish a desensitization plan or other behavioral interventions for those in need. Ms. Wooten informed the Monitoring Team of the progress of the dental workgroup to develop guidelines for dental desensitization. This document was in draft form and it relied on the determination by the dental clinic personnel to assess the ability of individuals to cooperate with routine dental procedures. The draft dental desensitization guidelines identify the levels of compliance as Type I, Type IIA, Type IIB, and Type III. Type I and Type IIA are classifications of individuals that are mild and moderately compliant and do not require the need for desensitization. Type IIB and Type III classifications are for those individuals who require the use of sedation or restraint to complete a part or all of routine dental care. Once individuals were identified by the dental clinic, an assessment was made by psychology and a treatment plan developed, to reduce the need of pretreatment sedation. It was proposed that assessments and recommendations should be forwarded to the QMRP prior to the annual PSP, and via the PSP process the required training procedures would be developed and implemented. The four cases of TIVA sedation were reviewed for information about efforts to reduce the need for pre-treatment sedation. For Individual #217, no information was available. For Individual #244 the PSP stated that sedation would be needed prior to dental procedures. There were two training objectives: the first was specific to tooth brushing ability. The individual also had a training objective to take several (up to three) deep breaths to help relax. Training Documentation Request data collection sheets showed that the program was active. For Individual #270, the PSP indicated a need for desensitization to minimize pretreatment sedation; the discussion related to that item was that the individual received a desensitization program for tooth brushing. For the fourth Individual (#429), the PSP outlined action plans for the individual to be able to walk to the dental clinic without problematic behavior, to greet medical staff and to be able to wait in the dental area without problems.	

#	Provision	Assessment of Status	Compliance
		Overall, the Monitoring Team found that nurses assured safety during procedures, but there was no consistent format for nurse monitoring, particularly during medical pre-treatment sedation. Restraint Checklists were not used during medical pre-treatment sedation procedures or IV sedation. Sedation Checklists were used during IV dental sedation procedure and some off-campus procedures, but not for on-campus pre-treatment sedation for medical procedures. The Facility's initiatives to develop and implement plans to reduce the need for pre-treatment sedation were at an early stage of development.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. Review of Facility training documentation showed that there were adequate training curricula on the application and assessment of restraint. The training provided for restraint monitors who conduct face to face assessments, other than the competency based training described in Provision C.3, was reviewed; however, insufficient detail was available to determine if it was competency based. The Facility provided a list of 26 names of staff authorized to perform the duties of a restraint monitor. Conducting the Face to Face Assessment is one of the primary duties of a restraint monitor. The following classes were identified as being required if someone was to act as a restraint monitor, and therefore conduct Face to Face Assessments. 1. ABU0100 Abuse and Neglect 2. PMA0320 PMAB Basic 3. PMA0400 PMAB4: Restraint 4. PMA0700 PMAB7: Prevention 5. CPR0100 CPR Basic 6. RES0105 Restraint: Prevention and Rules for Use at MR Facilities 7. RES0110 Applying Restraint Devices 8. UNU0100 Unusual Incidents 9. PBS0100 Positive Behavior Support 10. RES0115 Restraint: Prevention and Rules for Use at MR Facilities The training records of 10 of the 26 staff designated as restraint monitors were selected for review. Based on review of these 10 training records, all (100%) staff designated as restraint monitors had successfully completed the training to allow them to conduct face-to-face assessment of individuals in restraint. An issue was identified by the Monitoring Team with respect to the timeframes associated with the Unusual Incidents class (UNU0100). Six of the 10 staff in the sample	Noncompliance

#	Provision	Assessment of Status	Compliance
	shall specify the schedule and type of monitoring required.	(60%) had not completed this class within the last 12 months. This was probably because the Central Training Department (CTD) identifies this class as being required once every 24 months. As a result any delinquency tracking report prepared by CTD would not include UNU0100 unless more than 24 months had transpired since the last training. While this provision of the SA does not specifically require annual training/refresher training, other sections of the SA and State office policy do. The Monitoring Team has the expectation that the core courses identified below are to be completed at 12-month intervals for restraint monitors. Material was provided to the Monitoring Team from the Psychology Department in response to a document request asking for curricula for training conducted by the Psychology Department separate from formal CTD/DADS classes. This material consisted of the sign-in sheet for training conducted 1/13/11 labeled "Restraint Monitoring Training" and a copy of the Restraint Checklist and FFAD documents. Through interview the Monitoring Team was told the training consisted of going through the forms item by item to ensure that staff acting as restraint monitors understood each data item. All ten of the restraint monitors selected for review attended this training. Because there is not any formal curriculum for this training the Monitoring Team is unable to validate whether or not the training is competency based. Based on a review of 25 non-medical restraint records (Sample C.1), a face-to-face assessment was conducted in 22 of 25 incidents of restraint (88%) by an adequately trained staff member. The three restraint records that did not meet this criterion were: 1. For Individual #483 (2/19/11) in the Notifications section of the Restraint Checklist the notations were "nurse not notified", "monitor not notified", and "psychologist not notified." 2. For Individual #127 (1/21/11) there was no entry in the Notifications section of the Restraint Checklist in the Restraint Monitor section. There were two FFADs in this file, each signed by a different designated restraint monitor. Without a corresponding entry on the Restraint Checklist the Monitoring Team cannot determine which monitor was called when. 3. For Individual #720 (2/23/11) in the Notifications section of the Restraint Checklist the staff reported as the restraint monitor was not on the list of authorized restraint monitors provided by the facility. Additionally, three of the Restraint Checklists presented confusing information making it difficult for the Monitoring Team to validate SA compliance. 1. For Individual #669 (2/26/11) two staff names were in the restraint monitor section of the Restraint Checklist. One is an approved monitor and the other is not. The Face to Face Assessment was completed by the approved restraint monitor.	

#	Provision	Assessment of Status	Compliance
		2. For Individual #537 (1/30/11) two staff names were in the restraint monitor section of the Restraint Checklist. One is an approved monitor and the other is not. The Face to Face Assessment was apparently completed by a third person as the signature on the FFAD appears to be a name different than either name on the Restraint Checklist. 3. For Individual #110 (3/1/11) the name on the Restraint Checklist appears to be the first name of two different staff. The FFAD was completed by an approved restraint monitor whose first name matches one of the first names on the Restraint Checklist. One of 25 (4%) non-medical restraint records in the sample did not include an FFAD. For Individual #483 (2/19/11) the Restraint Checklist was completed several weeks after the restraint (basket hold) occurred. Documents provided to the Monitoring Team provided the following explanation: "the incident was discovered when another individual's guardian was complaining about an act of aggression towards her family member. When the camera monitors went to watch the tapes for the client to client incident, they discovered a restraint had occurred. They then checked to see if anything had been reported/documented, and there was no evidence that paperwork had been generated or notification was given to the appropriate people. The QMRP was notified the afternoon of 3/8/11 that a restraint had occurred 3 weeks prior, and a checklist was generated." The FFAD document includes an entry for "time monitor arrived." The Monitoring Team views this time as the time the assessment began. For 23 of 25 instances (92%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. Records that did not contain this documentation included the restraint of Individual #483 which was not discovered until three weeks after it occurred and restraint of Individual #669 (2/26/11) which was initiated at 10:45am and the restraint monitor arrived at 11:15am. In 24 instances (96%), the documentation on the FFAD showed that an assessment was completed of the application of the restraint. The record that did not contain this documentation included the restraint of Individual #483 which was not discovered until three weeks after it occurred. In 24 instances (96%), the documentation on the FFAD showed that an assessment was completed of the circumstances of the restraint. The record that did not contain this documentation included the restraint of Individual #483 which was not discovered until three weeks after it occurred. None of the 25 non-medical restraint records in the sample indicated an alternative	

#	Provision	Assessment of Status	Compliance
		physician-ordered monitoring schedule. Separate from the sample (Sample C.1) 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 as they involve two individuals with special circumstances presenting unique clinical challenges. The Facility reported one instance 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. Based on a review of 25 restraint records for restraints that occurred at the Facility (Sample C.1), there was documentation that a licensed health care professional: ▪ Conducted monitoring at least every 30 minutes from the initiation of the restraint in 10 (40%) of the instances of restraint. Listed below are Individuals and date of each restraint record where this did not occur: o Individual #127: 1/21/11 at 8:48 a.m. o Individual #127: 2/1/11 at 10:17 a.m. o Individual #127: 2/1/11 at 10:39 a.m. o Individual #127: 2/1/11 at 11:13 a.m. o Individual #127: 2/1/11 at 10:56 a.m. o Individual #127: 2/1/11 at 10:51 a.m. o Individual #624: 1/26/11 at 5:52 p.m. o Individual #624: 2/6/11 at 8:33 a.m. o Individual #624: 2/26/11 at 9:25 p.m. o Individual #12: 1/24/11 at 9:30 a.m. o Individual #537: 1/31/11 at 10:40 p.m. o Individual #483: 2/19/11 at 6:25 p.m. o Individual #720: 2/23/11 at 12:10 p.m. o Individual #667: 2/26/11 at 10:45 a.m. o Individual #110: 3/1/11 at 9:46 p.m. ▪ Monitored and documented vital signs in 16 (64%). Listed below are Individuals and date of each restraint record where this was not present: o Individual #483: 2/19/11 at 6:25 p.m. o Individual #127: 1/21/11 at 8:23 a.m. o Individual #127: 1/21/11 at 8:48 a.m. o Individual #624: 2/26/11 at 9:25 p.m. o Individual #624: 2/6/11 at 8:33 a.m. o Individual #12: 1/24/11 at 9:30 a.m. o Individual #720: 2/23/11 at 12:10 p.m. o Individual #12: 1/24/11 at 10:50 a.m.	

#	Provision	Assessment of Status	Compliance
		o Individual #653: 3/11/11 at 1:42 p.m. ▪ Monitored and documented mental status in 18 (72%). Listed below are Individuals and date of each restraint record where this was not present: o Individual #127: 1/21/11 at 8:23 a.m. o Individual #127: 1/21/11 at 8:48 a.m. o Individual #127: 1/21/11 at 8:50 a.m. o Individual #127: 2/20/11 at 8:55 a.m. o Individual # 624: 2/6/11 at 9:25 a.m. o Individual # 624: 2/26/11 at 8:33 a.m. o Individual #483: 2/19/11 at 6:25 p.m. Based on documentation provided by the Facility, one restraint incident had occurred off the campus of the Facility in the last six months. This restraint of Individual #12 occurred at school on 1/24/11. For this restraint a licensed health care professional: ▪ Conducted monitoring within 30 minutes of the individual's return to the Facility ▪ Did not monitor and document vital signs ▪ Monitored and documented mental status The Monitoring Team interviewed the Nurse Operating Officer regarding the failure of nurses to consistently complete the required 30 minute monitoring. It was reported that often nurses were not notified of restraint incidents, or if they were notified it was after the fact. Often nurses did not complete vital signs because the individuals refused and/or, even when they returned to baseline behavior, nurses were reluctant to attempt to take vital signs for fear it would result in another maladaptive behavior incident. The Facility needs to ensure that nurses are notified immediately when restraints were applied. Once nurses are notified of the application of restraints they need to monitor individuals within 30 minutes according to the restraint policy and document their assessment findings on the Restraint Checklist. If the nurses are not notified until after individuals have been released from restraints the nurses need to document the time they were notified, complete the required monitoring assessments, including vital signs, mental status, and whether or not the restraint usage caused injury or resulted in any negative health event and document their findings in the Post-Restraint Assessment Section of the Restraint Checklist.	
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	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. A sample (Sample C.1) of 25 Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements:	Noncompliance

#	Provision	Assessment of Status	Compliance
	bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	1. In 25 (100%), continuous one-to-one supervision was documented. 2. In 25 (100%), the date and time restraint was begun was documented. 3. In 25 (100%), the location of the restraint was documented. 4. In 15 (60%), information about what happened before, including the change in the behavior that led to the use of restraint was documented. The other 10 did not include sufficient information describing the change in behavior that led to the use of restraint. 5. In 14 (56%), the interventions taken by staff prior to the use of restraint were documented and are adequate for post restraint review. Individual #127 had an SPCI and was frequently restrained. This individual represents eight of the 25 restraints in the sample. None of the eight restraint checklists indicated that interventions in his Safety Plan were attempted prior to restraint. Individual #624 had an SPCI and was frequently restrained. This individual represents six of the 25 restraints in the sample. There was no indication on three of the restraint checklists that indicate that interventions in his Safety Plan were attempted prior to restraint. 6. In 24 (96%), the specific reasons for the use of the restraint were documented. 7. In 24 (96%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated on the restraint checklist. One restraint checklist did not include any entry in the type of restraint section. 8. In 25 (100%), the names of staff involved in the restraint episode were indicated on the restraint checklist. Sixteen (64%) of the restraints in the sample included use of the horizontal side-lying technique. In each of these 16 restraint episodes at least two staff were listed as applying the restraint. 9. The Restraint Checklist documented observations of the individual and actions taken by staff while the individual was in restraint, including: • In 24 (96%), the observations documented at least every 15 minutes and at release. Only one restraint in the sample exceeded 15 minutes. Individual #127 (2/1/11) was restrained for 21 minutes. The restraint checklist does not document any observations other than that noted at the start of the restraint and the release from restraint. • In 24 (96%), the specific behaviors of the individual that required continuing restraint were noted; and • Because of the short duration of 24 of 25 restraint episodes reviewed there was no obvious need for staff to provide, during the restraint, opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. The one restraint that lasted 21 minutes occurred mid-morning so it was also unlikely that there was any obvious need for staff to provide, during the restraint, opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. For this	

#	Provision	Assessment of Status	Compliance
		individual the FFAD checked "yes" in response to item 4.3 – timely opportunities provided for movement, exercise, to toilet, and to drink fluids. 10. In 24 (96%), the level of supervision provided during the restraint episode was recorded on the restraint checklist. 11. In 25 (100%), the date and time the individual was released from restraint was recorded on the restraint checklist. 12. In 22 (88%), the results of assessment by a licensed health care professional were documented as to whether there were any restraint-related injuries or other negative health effects. This was not the case with Individuals #483 (2/19/11), #653 (3/11/11), and # 127 (2/20/11). In a sample of 25 records (Sample C.1), FFADs had been completed for 24 (96%). These forms contained little narrative information but were generally complete in checking all the required boxes on the form. Care was not always taken in completing these forms. For example, Individual #12 was in a brief physical hold restraint. The restraint checklist release time was noted as the same time of application (10:50am). This might have occurred if the restraint duration was less than one minute, but the Monitoring Team could not determine that. On the FFAD several items are checked "yes" when clearly N/A was the appropriate response. For example, "medications given in the time period prescribed if in restraint at med pass" and "meal offered as near to mealtime as possible if in restraint at mealtime." Entries such as these are of concern to the Monitoring Team as they suggest the restraint monitor completing the FFAD is not engaged in critical thinking and may be only concerned with completing the paperwork. It is possible to expand upon the required data in the FFAD to include more complete data from which the IMRT and the individual's Personal Support Team may better understand circumstances and develop strategies to address issues impacting restraint use. For example, the Monitoring Team has observed a process at another SSLC where a psychologist reviews each restraint episode and writes a debriefing which addresses the following questions: 1. Describe the resident at the time the restraint was used? What was the resident doing that required restraint? What types of emotions were being shown by the resident? 2. Describe what led up to the restraint. What was going on in the environment prior to when the resident was displaying challenging behavior? What might have caused the resident to act the way he or she did? 3. When the resident first started showing that he or she was upset, and started displaying the precursors of the challenging behaviors that led to restraint, how did staff try to calm the resident? What interventions were tried prior to	

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		restraint, and how did the resident respond? 4. How can we prevent the need for restraining this resident in the future? If a similar situation develops, is there anything we can do instead of restraining the resident? Is there anything we can change in the environment where the restraint occurred that might make it less likely that the resident will again need to be restrained there? 5. Were injuries noted secondary to the restraint? A psychologist prepares the debriefing document after interviewing all staff involved in the restraint and working with the individual prior to the restraint episode. For the most part the content of the debriefing document is sufficiently detailed to be useful to the psychology staff and the PST in determining future actions that may prevent the need for restraint. A sample of 19 instances of individuals who received medical restraint was reviewed (Sample #C.3). These restraints were selected from a larger set of medical restraint documentation provided to the Monitoring Team. This sample included 13 instances of pre-treatment sedation and six instances of mechanical restraint. The documentation provided to the Monitoring Team with respect to the 13 instances of pre-treatment sedation was insufficient to validate that restraint monitoring had been completed as required by the facility policy. DSSLC Policy CMGMT-21 requires: If a health care provider or dentist orders a use of restraint for medical/dental treatment the written order must include: 1. Type of restraint 2. Clinical justification for the use of the restraint 3. Duration of the order 4. The schedule and type of monitoring required 5. Special instructions for the individual's care, if any, while restraints are being used. The policy further states "while an individual is restrained, staff must monitor the individual as ordered to ensure that the individual is not in physical distress and has not sustained an injury from the restraint. The evaluations will be documented on the Restraint Checklist and in the integrated progress notes." The material provided to the Monitoring Team did not address this requirement. The Monitoring Team asked for all documentation associated with the medical restraints in the sample, including restraint checklist, face-to-face assessments, medical orders, physician specified monitoring schedule, any standard facility protocol for monitoring medical restraint, any PSP information regarding development and/or implementation of	

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		plans to minimize use of medical restraint for the individual (including data sheets if a program was developed and implemented), documentation of review activity, and any other information that would be helpful in understanding the circumstances associated with this restraint use. The information provided by the facility in response to this request was insufficient to enable a review by the Monitoring Team in 13 of 13 cases of pre-treatment sedation (100%). For example, 12 of 13 (92%) cases did not include a restraint checklist even though a Restraint Checklist is clearly required by policy and necessary to assess the circumstances associated with restraint use. While some of the policy required information exists in other documents the intent of the Restraint Checklist (and any attachments to it) is to ensure all relevant restraint information is one place. Among other reasons, this is necessary to facilitate the post restraint review process required by the SA and by State policy. Additionally each of the 13 files put together for the Monitoring Team contained very dissimilar information leading the Monitoring Team to the conclusion that the DSSLC does not have an organized system for the management of pre-treatment sedation that will facilitate compliance with the SA. One further example of this is that the Monitoring Team asked three different administrators where in the record pre-treatment sedation restraint information could be located and got three different answers. This appeared to be correct in that a single instance of pre-treatment sedation may have some documentation associated with the restraint in each of the three sections noted by the administrators. For anyone reviewing pre-treatment sedation restraint, including DSSLC auditors, this makes it very difficult to find necessary documentation. The information presented for the six instances of mechanical restraint was better organized and a Restraint Checklist was present in each case. Four of the six cases in the sample represented use of mechanical restraint in conjunction with IV sedation. For these cases little was documented on the Restraint Checklist. Most documentation was in medical records but not presented to the Monitoring Team in an organized manner which would enable review to assess compliance with the SA. Presumably, this would also make it difficult for the Facility to conduct the post restraint review activity required by the SA and State policy. Individual #472 was the only individual for whom there was an instance of use of chemical restraint. The only documentation the Facility could provide to the Monitoring Team regarding this restraint was a progress note indicating it occurred. There was no Restraint Checklist, consultation form, or any other documentation required by DSSLC or State policy. Facility and State policy with respect to the use of chemical restraint was not followed.	
C7	Within six months of the Effective	According to Facility documentation, during the six-month period prior to the on-site	Noncompliance

#	Provision	Assessment of Status	Compliance
	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:	review, a total of five individuals were placed in restraint more than three times in any rolling thirty-day period. Documentation for five individuals (100%) who had three or more restraints during a rolling thirty day period was reviewed to determine if the requirements of the Settlement Agreement were met. The following documents were reviewed**:** the annual PSP, PSP updates, Special Program Objectives (SPOs), Positive Behavior Support Plans (PBSPs), structural and functional assessments (SFAs), 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, task analyses, and behavioral and functional assessments. The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. For five of the individuals/instances reviewed (100%), individuals' teams met to discuss the restraints.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	For zero of the individuals reviewed (0%), individuals' teams reviewed the individual's adaptive skills. The following are examples of where teams failed to do this adequately: • No individuals living at DSSLC had received an adaptive behavior assessment within the past 12 months. For three of the individuals/instances reviewed (60%), individuals' teams reviewed the biological, medical and psychosocial factors. The following are example of individuals who whom this was done appropriately: • For Individuals #127, #337, and #381, the record included a detailed discussion of biological, physical, and medical conditions as related to undesired behavior. The following are examples of where teams failed to do this adequately: • For Individuals #119 and #624, discussions of biological, physical, and medical conditions were too brief and general to provide insight into the causes of the undesired behaviors.	Noncompliance
	(b) review possibly contributing environmental conditions;	For one of the individuals/instances reviewed (20%), individuals' teams reviewed the possibly contributing environmental conditions. The following are examples of individuals for whom this was done appropriately: • For individual #381, specific environmental contingencies for the undesired behavior were assessed and identified. The following are examples of where teams failed to do this adequately:	Noncompliance

#	Provision	Assessment of Status	Compliance
		• For Individuals #119, #127, #337, and #624, the available assessments did not specifically identify the motivating operations, setting events, antecedents or consequences for the undesired behavior.	
	(c) review or perform structural assessments of the behavior provoking restraints;	For one of individuals/instances reviewed (20%), individuals' teams reviewed and/or performed structural assessments of the behavior provoking restraints. The following are examples of individuals for whom this was done appropriately: • For Individual #381 a functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis was completed. The following are examples of where teams failed to do this adequately: • For Individual #127, the most recent functional assessment was completed over a year prior to the site visit when the individual had lived at DSSLC for less than a month. Functions were identified based upon discussions with the individual's parents regarding behavior displayed prior to admission.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	The Behavior Services department at DSSLC combines the functional assessment and structural assessment into a single process. Please refer to Provision C.7(c).	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the	For five of the individuals reviewed (100%), individual had a PBSP. Of the 5 individuals in the sample who had PBSPs, the following was found: • One (20%) was based on the individual's strengths; • Four (80%) specified the objectively defined behavior to be treated that led to the use of the restraint; • Four (80%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint; and • Zero (0%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. The following are examples of individuals who had inadequate PBSPs: • Individuals #119, #127, and #137 had PBSPs that lacked a rationale for selecting the proposed intervention. • Individuals #381 and #684 had PBSPs that lacked a specific function for the identified target behavior. Although environmental contingencies had been assessed for Individual #381, the PBSP did not include statements or evidence to support that the intervention was based upon a specific functional hypothesis. • For Individual #119, the following limitations were noted in the PBSP. o The PBSP reflected that treatment records were used in the assessment of the target behavior. It was later stated in the PBSP that treatment records were not available.	Noncompliance

#	Provision	Assessment of Status	Compliance
	individual's ISP;	o The PBSP stated that baseline data were unavailable immediately below a graph of behavior data since admission. The PBSP in the same section also stated that "data will be reevaluated as it accrues." Baseline data are by definition pre-treatment data. Therefore, the currently available data could constitute a baseline if an adequate description of current conditions is provided, and ongoing determination of "baseline" data would be inappropriate and detrimental to the treatment process. o The Treatment method did not specify a schedule for training, the number of trials per training session, or a procedure for reinforcing desired responses. o The PBSP did not specify treatment expectations and timeframes for achieving those expectations. o Individual #119 had demonstrated potentially dangerous behaviors such as self-injury and statements of suicidal intent. Functions identified included escape, attention and obtaining tangible objects. The treatment methodology targeted only agitation. The Safety Plans of the individuals in the sample were reviewed. The following represents the results: • In four out of four of the Safety Plans reviewed (100%), the type of restraint authorized was delineated; • In four (100%), the maximum duration of restraint authorized was specified; • In four (100%), the designated approved restraint situation was specified; and • In four (100%), the criteria for terminating the use of the restraint were specified.	
	(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	DSSLC had implemented the first phase of a process to measure inter-observer agreement (IOA) for PBSC data. As the IOA procedure was implemented only a few weeks prior to the site visit, it was not possible to develop a clear measure of whether efforts at collecting IOA data were successful. Nevertheless, the effort to determine the reliability of treatment data was welcomed by the Monitoring Team. For zero of the individuals reviewed (0%), the individual's behavioral data and/or treatment integrity checks showed that the PBSP was implemented with a high level of treatment integrity.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	In four of the records reviewed (80%), there was documentation that the individual's PBSP had been revised as appropriate. The following are examples of individuals for whom this was done appropriately:	Noncompliance

#	Provision	Assessment of Status	Compliance
		• For Individual #119, a PBSP was developed and implemented on 01/11/2011 following displays of verbally disruptive behavior, suicidal gestures, self-injurious behavior, unauthorized departures and aggression toward property. The PST monitored the response to the PBSP on a monthly basis. Data revealed that the undesired behaviors displayed by Individual #119 decreased within two months. The PST determined that the PBSP should continue. The following are examples of where teams failed to do this adequately: • For Individual #127, overall displays of aggression increased beginning in June, 2010 and remained elevated into November 2010. The overall frequency of aggression increased again in January, 2011 by more than 500% over previous maximum levels. Despite elevated levels of aggression, the PST did not recommend a revision to the PBSP until the annual PSP on 3/3/2011.	
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.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. The DSSLC process for reviewing each episode of restraint, as reported by staff, begins with a FFAD done by the restraint monitor immediately after the restraint episode. The restraint episode is reviewed in the unit morning meeting the next business day with whatever information has been prepared by the time of the meeting. This often consists of verbal reports from staff. It is reviewed that same day by the IMRT, again often based on verbal reports from staff, either the Unit Director, Psychology staff, or both. Documentation of these reviews is expected to be in IMRT meeting minutes but it was usually quite general, often just noting date and time and that a review occurred. There is also space on the FFAD to document that a unit review took place and the date. This was properly documented in 18 of the 25 restraints reviewed in the sample (72%). In the 25 documentation files prepared by the DSSLC for the Monitoring Team, only one contained documentation of IMRT review (4%). This was for Individual #483 (2/19/11). The Monitoring Team believes this was probably an oversight in the preparation of these documentation files since a review of IMRT minutes indicates restraint use as a regular agenda item. If a restraint related issue is referred to the PST the results are ordinarily documented in a Personal Support Plan Addendum (PSPA) that becomes part of the permanent record. DSSLC policy requires that "the PST will meet and review each use of restraint as a crisis intervention that is not authorized by a SPCI within one working day of the restraint; documented in a PSPA." Eight of the 25 restraints in Sample C.1 involved individuals	Noncompliance

#	Provision	Assessment of Status	Compliance
		without a SPCI. Only one documentation file (13%) contained a PSPA. This was for Individual # 12 (1/25/11). The Restraint Reduction Committee included on its agenda a case study each month. This is typically the most difficult behavioral/restraint case at the time of the meeting. The Quality Assurance/Quality Improvement Council also included restraint use on its agenda although this would not typically include any discussion of an individual restraint.	

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

1. Not all requirements of the SA are reflected in DSSLC policies that govern restraint. This is especially problematic with respect to medical restraint. This needs to be corrected.
2. DSSLC restraint policies need to be uniformly implemented.
3. Medical and nursing staff need additional training on restraint related policy and procedure.
4. Direct Care Professionals need additional training on the fundamental aspects of restraint policy and procedure.
5. Behavior support plans should include concrete strategies for deescalating behavioral incidents specific to each individual.
6. A member of each of the relevant clinical disciplines should participate in reviews of frequent use of restraints to assure active discussion of efforts to minimize the use of restraints.
7. PSP Addendums should reflect on and document active treatment efforts being made.
8. The Facility needs to ensure that nurses are notified immediately when restraints were applied. Once nurses are notified of the application of restraints they need to monitor individuals within 30 minutes according to the restraint policy and document their assessment findings on the Restraint Checklist. If the nurses are not notified until after individuals have been released from restraints the nurses need to complete required documentation.
9. Revise behavior support plans if they are not effective tools for direct support staff responsible for plan implementation.

The following are offered as additional suggestions to the facility:

1. Implement a formal written system of psychology staff review and debriefing of each crisis intervention restraint.
2. Continue the auditing/monitoring activity that is producing compliance reports and use these data to initiate process improvements.
3. Implement a procedure to record on the Restraint Checklists brief holds of less than one minute.
4. Continue the practice of immediate retraining of staff as auditors/monitors discover issues.
5. Use compliance data to isolate problem areas, e.g. by home/shift and use this analysis to target resource application.
6. The Facility might consider revising the restraint documentation forms to document when a restraint is less than one minute in duration.

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. DSSLC Plan of Improvement 3/15/11 2. DSSLC Section D Presentation Book (undated) 3. DADS Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation 6/18/10 4. DADS Policy 02.2 Incident Management 6/18/10 5. DADS Policy 042.3 Video Surveillance 8/6/10 6. DSSLC Policy CMGMT-01A Protection from Harm – Abuse, Neglect, and Exploitation 7/30/10 7. DSSLC Policy CMGMT-01B Protection from Harm – Incident Management 7/30/10 8. DSSLC Appendix A to Policy 2.2 Injury Reporting 5/17/10 9. DSSLC Completing Incident Investigation Reports for Discovered Injuries 7/23/10 10. DSSLC Policy CMGMT-17 Home Shift Log Policy 2/24/11 11. DSSLC Policy Client Management-28 – Guidelines for Staff Interaction with Individuals 2/23/10 12. DSSLC Policy Client Management-01B Injuries to Persons Served in Residential Programs 3/1/09 13. DSSLC Policy Client Management-01C Reporting, Documenting, and Review of Unusual Incidents 6/8/09 14. Training Curriculum for Course ABU0100 Abuse and Neglect 7/13/09 15. DSSLC Retraining Curriculum for Course ABU0100 Abuse and Neglect 7/20/10 16. Sample of Employee Training Records 17. DADS Report MHMR0102 Percent of All Employees Completing Courses of Training Program 3/1/11 18. Sample of Acknowledgment of Responsibility for Reporting Abuse, Neglect, and Exploitation employee forms. 19. DSSLC Annual Employee Registry Check and Fingerprint Criminal History Check printed 3/28/11 20. DADS Instructions for Processing Volunteer Criminal Background Checks (undated) 21. Sample volunteer records 22. "You Have the Right" poster 7/17/09 23. "Report Abuse or Neglect" poster 4/05 24. "Prevent Abuse & Neglect Poster" undated 25. Current mailer to LARs regarding abuse, neglect, and exploitation 26. Incident Management Review Team Meeting minutes for 1/3/11, 1/10/11, 1/18/11, 1/24/11, 1/31/11, 2/7/11, 2/14/11, 2/22/11, 2/28/11, 3/7/11, and 3/28/11 27. Trend Analysis Report 3/31/11 28. Individual Training Records for Facility and Department of Family and Protective Services (DFPS) Investigators 29. Abuse and Neglect Allegations log 10/1/10 to 3/30/11 30. Log of employees reassigned from client contact 9/1/10 to 12/18/10 31. Unusual Incident log 10/1/10 to 3/30/11

	32. Serious Injury Report 9/1/10 to 3/15/11 33. Serious Incident log 9/1/10 to 3/15/11 34. Injury Summary (by individual) 10/1/10 to 3/15/11 35. Discovered Injury Log 10/1/10 to 3/28/11 36. Discovered Injury Investigation for Individuals #740, #286, #383, ##345, #392, #211, #571, #188, and #722 37. UIRs 11-143, 145, 050, 031, 091, 076, 064, 017, 120, 112, 039, 113, 158, 043, 035, 093, 082, 103, 079, 133, 052, 158, 151, 027, 059, 102, 132, 099, 107, 028, 055, 077, 135, and 150 38. DFPS Investigation Files 38569574, 38556104, 38567591, 38323204, 38273576,38477148, 38467706, 38409442, 38050081, 38556104, 38521049, 38298061, 38521292, 38469093, 38502224, 38468790, 38587928, 38324307, 38698722, 38118497, 38305750, 38278844, 38480089, 38662813, 38567489, and 38595748 39. OIG case information 06567-11 and 06611-11 40. List of individuals for whom DFPS conducts a streamlined investigation 41. Self-Advocacy meeting minutes 1/18/11 and 2/25/11 42. 2010 Guardian/LAR Satisfaction Survey 43. CMS 2567 received from DADS for survey of 3/11/11 44. QA/QI committee meeting minutes 2/17/11, 1/20/11, and 1/6/11 **People Interviewed:** 1. Deb Salsman, Director of Incident Management 2. Jeron Dotson, Incident Manager 3 Lori Powell, Director of Quality Assurance 4 Ken Horstman, Director of Residential Services 5 Elaine Davis. Director of Training and Development 6 Dora Tillis, Assistant Director of Programs 7 Sheila Carpenter, SA Coordinator 8 Andy Maher, Director of Consumer and Family Relations 9 Nora Brookins, Incident Auditor 10 Sgt. Pamela Busfield, OIG 11 Ten Direct Care Professionals and two individuals living at DSSLC **Meetings Attended/Observations:** 1. Incident Management Team (IMRT) 3/28/11 2. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 3/31/11
	Facility Self-Assessment: The DSSLC POI reported substantial compliance with four of the five provisions in Section D of the SA. The Monitoring Team was able to substantiate compliance with two of these four provisions. The Monitoring Team concurred with DSSLC that it is in substantial compliance with provisions D.1 and D.5. Provision D.1 addresses policy requirements and commitments of zero tolerance of abuse and neglect and mandatory reporting. Provision D.5 addresses required background checks of employees and volunteers. The DSSLC reported substantial compliance with provision D.2 even though it reported it was not in

	substantial compliance with one component of D.2, component (i). In order for a provision of the SA to be in substantial compliance all components of the provision must also be in substantial compliance. For D.2 DSSLC reported it was in substantial compliance with eight of nine components. The Monitoring Team determined DSSLC was in substantial compliance with six of nine components. Interestingly, the Monitoring Team determined DSSLC was in substantial compliance with component (i) which DSSLC reported it was not in compliance. This component addresses serious injury underreporting audits. The DSSLC reported it had not as yet achieved substantial compliance with provision D.3 and the Monitoring Team concurs. DSSLC reported it was in substantial compliance with eight of the 10 components of the provision. The Monitoring Team determined that DSSLC was in substantial compliance with only five of the 10 components. As was the case for provision D.2, the Monitoring Team determined substantial compliance for one component (d) where the DSSLC reported noncompliance. This component addresses the safeguarding of evidence.
	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 has had an obvious effect on the quality of some investigations. 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 for the most part they did not represent large numbers or alarming issues. Management systems are under continual refinement to minimize this, including a UIR review process that audits 14 UIRs each month. Two audits are done by the QA Director, two by the Incident Management Coordinator, and 10 by the QA Auditor. There continues to be a problem with timely response from DFPS in initiating investigations. Initial investigatory activity often exceeded the 24 hour requirement, sometimes by days. DSSLC needs to modify its Trend Analysis Report to reflect specific data elements on type of allegations and disposition by type not just for the current month but over time, as occurs with some other data elements in the report. To facilitate abuse/neglect reporting, the Facility put in place a three digit number in its phone system that automatically connects with DFPS. This enables staff to remember a three digit number and have quick access to DFPS to report allegations. The Monitoring Team tested the three digit number and was immediately connected to DFPS intake. DSSCLC Procedure: Injury Reporting (5/17/10) does not address the subject of reporting serious injuries to the Facility Director and in fact five of six serious injuries reviewed by the Monitoring Team were not reported timely to the Facility Director/designee. This requirement is found in the DSSLC Incident Management policy. Given the percent of injuries in which timely reporting did not occur, either staff do not know the Incident Management policy, refer instead to the Injury Reporting policy, or are not following policy.

	Even though staff had received training in abuse/neglect policy and procedure it was apparent key elements of the learning has not been retained. Compliance with required background checks was confirmed.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. The Facility's policies and procedures included a commitment that abuse and neglect of individuals will not be tolerated and required that staff report abuse and/or neglect of individuals. According to the DSSLC policy CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10), staff were required to report abuse, neglect, and exploitation to DFPS within one hour by calling the DFPS 1-800 number. This was consistent with the requirements of the Settlement Agreement. The facility also had in place a three digit number in its phone system that automatically connects with DFPS. This enables staff to remember a three digit number and have quick access to DFPS to report allegations. The Monitoring Team tested the three digit number and was immediately connected to DFPS intake.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team does not concur. This provision of the SA includes nine components (a-i). All must be in substantial compliance in order for the provision to be in SA. The DSSLC POI reported eight of the nine to be in substantial compliance. Therefore, this provision cannot be rated as being in substantial compliance. Additionally, the Monitoring Team determined that five components rated as in substantial compliance by the DSSLC were not. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this provision of the SA.	Noncompliance
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse,	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team does not concur.	Non compliance

#	Provision	Assessment of Status	Compliance
	neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. DSSLC policy CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) provides instruction specific to the reporting of different types of serious incidents including in section IV.C.1 "any other incident determined serious or significant by the Director." This is sufficient to meet the reporting requirements associated with this component of the SA. The Monitoring Team intended to provide statistical summaries with respect to abuse, neglect, and exploitation allegations, investigations, and disposition of investigations in this section of the report. Ordinarily these data are presented in Trend Reports prepared by each SSLC. The data in the DSSLC Allegations Trend Report (2/28/11) did not delineate DFPS cases by type (i.e. abuse, neglect, and exploitation) and did not provide data on disposition except for the case dispositions from the current month. These data also did not delineate by type of allegation. From a response to a document request DSSLC provided the following data. From January 1, 2010 through December 31, 2011 DSSLC had: 1. 143 Abuse allegations of which 15 were substantiated, 92 were unsubstantiated, and nine were inconclusive. No information was provided with respect to the other 27 investigations. 2. 84 Neglect allegations of which 16 were substantiated, 27 were unsubstantiated, and four were inconclusive. No information was provided with respect to the other 37 investigations. 3. 2 Exploitation allegations of which one was substantiated. No information was provided with respect to the other allegation. DSSLC needs to modify its Trend Analysis Report to reflect specific data elements on type of allegations and disposition by type not just for the current month but over time as occurs with other data elements in the report. DSSLC provided a report entitled Serious Injury Report, which listed serious injuries to individuals from 9/1/10 to 3/15/11. From this report the Monitoring Team was able to determine the DSSLC had 30 serious injuries during this time period. From these 30, six were selected for sample D.2 to assess the adequacy of the facility investigation process. Two samples of investigations were selected for review. These included: ▪ Sample D.1 included a sample of 19 DFPS investigations of abuse, neglect,	

#	Provision	Assessment of Status	Compliance
		and/or exploitation between 9/1/10 and 3/15/11. This sample included the following DFPS investigation reports 38323204, 38273576, 38477148, 38409442, 38050081, 38556104, 38521049, 38298061, 38521292, 38469093, 38502224, 38468790, 38587928, 38324307, 38698722, 38118497, 38305750, 38278844, and 38480089. ▪ Sample D.2 included a sample of six Facility investigations between 10/1/10 and 3/15/11. Sample D.2 consists of six serious injuries including UIRs 11-028, 055, 077, 099, 107, and 135. In reviewing Sample D.1 (DFPS case reports) six of 19 (32%) reported evidence that the initial report to DFPS did not occur within one hour of discovery or suspicion of the incident leading to the report to DFPS. This was the case for the following DFPS investigations: 38409442, 38305750, 38324307, 38556104, 38480089, and 38273576. In reviewing Sample D.2 (serious injuries) one of six (17%) were reported immediately (within one hour) to the Facility Director/designee. Those that were not reported within one hour included UIRs 028, 055, 077, 135, and 099. DSSCLC Procedure: Injury Reporting (5/17/10) does not address the subject of reporting serious injuries to the Facility Director. When staff do not follow the policy for reporting that policy was followed (as noted directly above), another way to determine whether training on policies has been competency-based and whether staff remain competent is to determine whether they can explain the policies. Based on an interview of 10 staff responsible for the provision of supports to individuals, only five (50%) were able to correctly describe the complete reporting procedures for abuse, neglect, and/or exploitation. One person did not mention calling the DFPS number or the three digit Denton number which connects to DFPS. Another person indicated the call should go to a four digit number which Denton uses as a general informational number. Improved staff knowledge is necessary to achieve substantial compliance with this component of the SA. Based on an interview of 10 staff responsible for the provision of supports to individuals, 10 (100%) were able to describe the reporting procedures for other serious incidents, noting they would call the nurse and/or their supervisor. None indicated they would call a campus administrator.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation	Substantial compliance

#	Provision	Assessment of Status	Compliance
	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.	(7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. Both policies contain provisions that if followed will achieve compliance with this component of the SA. Based on a review of 19 investigation reports included in Sample D.1 in every instance where an alleged perpetrator (AP) was known the AP was immediately placed in no contact status. Additionally, the Monitoring Team was provided with a log of employees who had been reassigned since 9/1/10. The log included the applicable UIR number, the date of reassignment, the outcome of the investigation, and the date the employee was returned to work if the employee was not discharged or had resigned. Review of 19 investigation files included in Sample D.1 showed there were no instances where staff who had been removed from direct contact and subsequently reinstated after a well-supported preliminary assessment posed a risk to individuals or the integrity of the investigation. Based on a review of the 19 investigation files in Sample D.1, it was documented that adequate additional action was taken to protect individuals in each case. For example: nursing assessments were done and treatment rendered as appropriate, alleged perpetrators were put in NDC (No Direct Care) status, and emotional assessments of victim trauma were conducted by psychology staff.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team does not concur. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. CMGMT 01A requires that all staff complete class ABU0100 Abuse and Neglect, and CMGMT 01B requires that all staff complete class UNU0100 Unusual Incidents at least yearly. These two classes are sufficient to demonstrate compliance with the SA. A review of the training curricula related to abuse and neglect was carried out for: a) new employee orientation; and b) annual refresher training. The results of this review were as follows: In relation to the requirement that training is competency-based, the material reviewed included provisions for trainees to demonstrate their understanding of what constitutes abuse, neglect, and exploitation and how to report observations or suspicion of abuse, neglect, or exploitation. The material also included adequate training regarding	Noncompliance

#	Provision	Assessment of Status	Compliance
		recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. Review of 21 staff records (Sample C.2), showed that 21 (100%) of these staff had completed competency-based training on abuse and neglect and unusual incidents prior to working directly with individuals. All 21 staff had completed Abuse and Neglect training within the last 12 months. Seven (33%) had not completed Unusual Incident training within the last 12 months and therefore were not compliant with the SA requirement of yearly training. Based on an interview of 10 staff responsible for the provision of supports to individuals, ▪ Four (40%) were able to list signs and symptoms of abuse, neglect, and/or exploitation with sufficient depth to demonstrate competency of understanding; and ▪ Five (50%) were able to describe the complete reporting procedures for abuse, neglect, and/or exploitation. Even though staff have received training it is apparent key elements of the learning has not been retained.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. Copies were requested of the forms for staff hired during the two full months prior to the on-site review. Based on a review of those forms, 141 of 141 (100%) of staff hired during this time period had signed the DADS required acknowledgement form 1020. This is the form required by DADS policy to document compliance with this component of the SA. The Monitoring Team identified several issues related to these completed forms. Four of the forms, although signed, were problematic with the dates that accompanied the signature. One did not indicate the year, one was dated one month before the start of employment, one was dated one month after the start of employment, and one was dated six weeks after the start of employment. Most forms were dated the start date of employment indicating this subject is addressed early in the New Employee Orientation (NEO) training. In addition to the four problematic forms noted above, an additional 15	Substantial compliance

#	Provision	Assessment of Status	Compliance
		forms were signed 2-3 weeks after the start date. It was not possible for the Monitoring Team to determine if these forms were signed while the employee was still in NEO or had already been assigned to on-the-job (OJT) training in a residential unit. It is unlikely any of these forms were completed after the staff person was able to work independently with individuals, that is, after completing their OJT requirements in the residential areas. The Facility should ensure that statements confirming new employees are aware of their obligation to report abuse, neglect, and exploitation are each signed prior to the date each individual begins working in a direct contact position. A sample of 21 staff (Sample C.2) was randomly selected to determine if annual acknowledgements had been signed. All 21 (100%) had current signed statements. The Monitoring Team randomly selected an additional 35 employees to validate this requirement. All 35 (100%) had current signed statements. Through document review and interview the Monitoring Team did not discover any instance of a mandatory reporter failing to report abuse or neglect although there were several instances of late reporting. In these instances appropriate personnel action was taken by the facility.	
	(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.	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team does not concur. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. DSSLC engages in limited activity directed at this component of the SA. Materials are provided to LARs prior to each individual's PSP meeting. Monitoring Team members attended numerous PSP meetings, which are identified in several sections of this report. None of these meetings included any discussion of abuse, neglect or other reportable incidents. In interviewing a sample of two individuals living at DSSLC, they were, after considerable prompting, able to describe what they would do if someone hurt them, or they had a problem with which they needed help. No serious incidents had been identified as being reported by an individual, their LAR, or others who were significantly involved in their lives. The Facility's self-advocacy meeting minutes did not indicate any recent review of	Noncompliance

#	Provision	Assessment of Status	Compliance
		incident reporting. It was reported that this topic is to be featured at the April meeting. The January meeting, attended by 17 individuals, focused on rights including calling your QMRP or the Rights Officer if something is bothering you or you want to file a complaint. The minutes did not specifically reference abuse or neglect. The February meeting, attended by 27 individuals, focused on living options.	
	(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.	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. A review was completed of the posting the Facility used. It included a brief and easily understood statement of: 1) individuals' rights; 2) information about how to exercise such rights; and 3) information about how to report violations of such rights. Observations by the Monitoring Team of living units and day programs on campus showed that most environments had postings of individuals' rights in an area to which individuals regularly had access. The Monitoring Team did observe several instances where postings were not in place, were not displayed prominently, or were in poor condition. An example of this was observations made in 526D on 3/30/11 at 12:30pm. Administrative staff reported they are in the process of laminating posters and/or using frames to ensure they stay in good condition. The Facility had an auditing process that included checking on the proper display of these posters. Results of these audits report occasional issues with the display of posters.	Substantial compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. Based on a review of 19 allegation investigations completed by DFPS (Sample D.1), DFPS had made law enforcement referrals in 10 cases. Three cases in the sample were administrative referrals back to the Facility and law enforcement referral was not	Substantial compliance

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		unnecessary. The remaining six cases for which there was not law enforcement referral were 38409442, 38556104, 38521049, 38502224, 38118497, and 38305750. Four of the six cases were allegations of neglect. Two were allegations of emotional/verbal abuse. The Monitoring Team determined that the decision not to make law enforcement referral in all six cases was appropriate. Based on a review of six investigations completed by the Facility (Sample D.2), law enforcement referral was not necessary or appropriate given the nature of the incident being investigated and the facts discovered during the course of the investigation. Additionally the Monitoring Team identified incidents that were not part of either sample but demonstrated appropriate referral to local law enforcement, including: UIR 11-059 alleged theft of an individual's money was referred to the Denton Police Department, UIR 11-102 alleged theft of an individual's money was referred to the Denton Police Department, and UIR 11-132 alleged theft of individual property was referred to the Denton Police Department.	
	(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.	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. Based on interviews with the Facility Director, Director of Incident Management, and the Incident Management Coordinator it was evident retaliation would not be tolerated and this was reinforced in training and during the course of individual investigations. The Facility had created a "Reporting Retaliation" poster which was displayed prominently throughout the facility. In interviewing a sample of two individuals, they were, after considerable prompting, able to describe what they would do if someone hurt them, or they had a problem with which they needed help. Neither understood the concept of retaliation. Based on an interview of 10 staff responsible for the provision of supports to individuals, eight (80%) were clear in their understanding that retaliation was not tolerated by the facility administration and if it occurred administration would take action. One staff did not really understand the concept of retaliation and one staff expressed fear of losing her job because of fear of retaliation related to a recent investigation. The Monitoring Team referred this concern to the Facility Director who followed up appropriately with the	Substantial compliance

#	Provision	Assessment of Status	Compliance
		staff person. Based on a review of investigation records (Sample D.1 and Sample D.2), there were no concerns noted related to potential retaliation. Separate from the samples, the Monitoring Team discovered an instance of perceived retaliation when reviewing UIR 11-143. A staff indicated they did not immediately report an observation believed to be neglect because she did not know who to report the allegation to and was afraid of retaliation. The employee was retrained in both abuse/neglect reporting and the prohibition against retaliation. The Facility was asked for a list of staff against whom disciplinary action had been taken due to their involvement in retaliatory action against another employee who had in good faith had reported an allegation of abuse/neglect/exploitation. The Facility indicated it did not have such a list because the only incident of perceived retaliation was that noted above by the monitoring team.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	In its Plan of Improvement (POI) the DSSLC reported that it had not as yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team believes the DSSLC has achieved substantial compliance. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. The POI reports noncompliance because the monthly audits continue to find some unreported injuries. This component of the SA requires that an audit process capable of detecting instances of unreported injuries be in place. DSSLC had such a process. 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, or if data entries are inconsistent, the auditor follows-up to insure an injury report, albeit quite late, is generated with appropriate backup documentation and/or inconsistent data elements are reconciled.	Substantial compliance
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	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address	Noncompliance

#	Provision	Assessment of Status	Compliance
	investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:	this provision of the SA.	
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team does not concur. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. The Monitoring Team review of this policy found it described the conduct of all such investigations and required that investigators be qualified. The policy specifies that Facility Investigators (and any other staff authorized to conduct investigations) successfully complete Comprehensive Investigator Training (CIT0100), Conducting Serious Incident Investigations (INV0100), and a class in Root Cause Analysis. The policy required that investigators have training in working with people with developmental disabilities, including persons with mental retardation. This was accomplished through successful completion of People with MR (MEN0300). The Monitoring Team believes this training, if completed as described, should be adequate for the conduct of investigations at DSSLC. Finally, the Facility policy required that investigators be outside of the direct line of supervision of the alleged perpetrator. The Monitoring Team did not review curricula used by DFPS in training its investigators and cannot comment on its content and whether or not it is competency based. Because DFPS case investigations reviewed by the Monitoring Team were generally thorough and comprehensive and case reports were generally well written, the Monitoring Team believes, at least for now, the training DFPS investigators received is achieving the desired results. DFPS reports its investigators are to have completed APS Facility BSD 1 & 2, or MH &MR Investigations ILSD and ILASD depending on their date of hire. While not required it appears many investigators also take a class titled "MH&MR Overview – APS Investigator Role." Completion of this class would demonstrate training in working with people with developmental disabilities. DFPS had nine investigators assigned to work DSSLC cases. The training records for	Noncompliance

#	Provision	Assessment of Status	Compliance
		these investigators were reviewed. Eight completed the requirements for investigations training, and the investigator who had not was a new hire and had not as yet been assigned any DSSLC cases. DSSLC had eight staff designated as investigators. The training records for these staff were reviewed. Three (38%) had completed the required training. The other five had completed the required training with the exception of Root Cause Analysis (RCA). To become compliant with this provision, the Facility will need to assure that the investigators complete all training required by the Facility. None of the staff designated as investigators had supervisory responsibilities that extend beyond the Incident/Risk Management Department therefore they are unlikely to be in the direct line of supervision of anyone subject to investigation.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team does not concur. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. The Monitoring Team did not identify language in either policy that addresses this component of the SA. An example of requirements that might be appropriate in the DSSLC assurances section of the policies, or the state center investigations section of the incident management policy might be: 1. Language that requires employees and agents to cooperate with DFPS investigators so that they are afforded immediate access to all records and evidence as necessary to conduct an investigation in a timely manner. 2. Language that requires administrative staff to assist in whatever way possible to make employees and agents who are relevant to the investigation available in an expeditious manner. 3. Language that makes it known that staff failure to cooperate with an investigation will result in disciplinary action. Despite the lack of a policy requirement the Monitoring Team did not find any instances of lack of cooperation in its review of the 19 DFPS investigations in Sample D.1.	Noncompliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation	Substantial compliance

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	investigations.	(7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ In 19 of 19 (100%) investigation records from DFPS (Sample D.1) no evidence of interference by one agency or the other was identified. Of the six investigation records from the Facility (Samples D.2.), none had been referred to law enforcement agencies. All were serious injuries where there was no suspicion of abuse or neglect, and therefore would not be reported to DFPS or law enforcement	
	(d) Provide for the safeguarding of evidence.	In its Plan of Improvement (POI) the DSSLC reported that it had not as yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team does not concur. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. While on site, the Monitoring Team observed the area the Facility uses for safeguarding evidence as well as actual evidence secured in a locked file cabinet in the locked office of the Incident Manager's office. Based on a review of the investigations completed by DFPS (Sample D.1) and the Facility (Sample D.2) any evidence that needed to be safeguarded was.	Substantial compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team does not concur.	Noncompliance

#	Provision	Assessment of Status	Compliance
	reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. CMGMT 01B Incident Management policy requires that investigations commence within 24 hours or sooner, if necessary. The policy contains additional requirements that, if followed, address this component of the SA. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Sample D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations (Sample D.1)</u> The following summarizes the results of the review of DFPS investigations: Eleven of 19 (58%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information, if any, included in the investigative report that described the steps taken to determine the priority of investigation tasks, as well as any documentation provided regarding any substantive investigatory tasks that were undertaken within 24 hours of DFPS being notified of the allegation. The following were the investigations for which adequate investigatory process did not occur within the first 24 hours or sooner: 1. Investigation 38278844 was reported to DFPS at 12:40pm on 10/11/10. The initial face-to-face interview with the alleged victim did not occur until 10/13/10 at 1:25pm. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. 2. Investigation 38118497 was reported to DFPS at 10:49am on 9/26/10. The initial face-to-face interview with the alleged victim did not occur until 9/28/10 at 11:05am. The individual is nonverbal and was unable to provide the investigator with any information. The DFPS investigator conducted a phone interview with the video surveillance monitor on 9/27/10 at 11:30am. Interviews of other staff did not begin until 9/30/10. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. 3. Investigation 38521292 was reported to DFPS at 5:47pm on 1/8/11. The initial face-to-face interview with the alleged victim was on 1/10/11 at 3:30pm. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. 4. Investigation 38521049 was reported to DFPS at 1:32pm on 1/8/11. The initial	

#	Provision	Assessment of Status	Compliance
		face-to-face interview with the alleged victim was on 1/10/11 at 11:30am. The alleged victim was nonverbal and unable to provide information; therefore, no information to begin an investigation was gathered. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. 5. Investigation 38298061 was reported to DFPS at 1:29pm on 10/18/10. The initial face-to-face interview with the alleged victim was attempted on 10/19/10 at 11:15am. The alleged victim was unavailable. A second interview was attempted later in the day and a third the next day. In each case the alleged victim was unavailable. On 10/21/10 at 10:00am an interview occurred with staff. Presumably, this interview could have been initiated earlier in the process, which would have prevented the delay in the initiation of the investigation. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. 6. Investigation 38477148 was reported to DFPS at 1:16pm on 12/12/10. The initial face-to-face interview with the alleged victim was on 12/14/10 at 12:55pm. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. 7. Investigation 38467706 was reported to DFPS at 5:34pm on 12/3/10. The initial face-to-face interview with the alleged victim was on 12/6/10 at 1:10pm. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. 8. Investigation 38409442 was reported to DFPS at 10:51am on 11/17/10. The initial face-to-face interview with the alleged victim was on 11/19/10 at 10:45am. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. Fifteen of the 19 investigations (79%) were completed within 10 calendar days of the incident. • For the four that were not completed within 10 days, two (50%) case files contained the Adult Protective Services Extension Request Form (38324307 and 38480089). In one case the investigation was completed within the timeframe allowed by the extension request. In the other case (38480089) the investigation was not completed within the timeframe allowed by the extension and no other extension form was provided to the Monitoring Team. Neither extension form adequately documented the "extraordinary circumstances" that made an extension necessary. In one case "new witnesses identified" was checked on the form. In the other case "witnesses need to be re-interviewed" was checked on the form. The Monitoring Team does not believe either of these circumstances represents extraordinary circumstances. Both are usual and customary components of a thorough and complete investigation and would be expected to	

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		occur within the timeframe called for in the SA. • Nineteen (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. • In six of the investigations reviewed, DFPS concerns and recommendations for corrective action were included. In all six the recommendations were appropriate to address issues identified by the DFPS investigator. <u>Facility Investigations (Sample D.2.a)</u> The following summarizes the results of the review of Facility investigations of serious injuries: Six of six (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing the UIR and determining the time of the first entry indicating any on site work activity by a facility investigator. Five of six (83%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. The investigation for UIR 107 involved a serious injury on 1/3/11. The investigation was not completed until 1/18/11. Six of six (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. In all six of the investigations reviewed, recommendations for corrective action were included. In all six of the investigations (100%), the recommendations appeared adequate to address the findings of the investigation.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. The contents of the investigation reports reviewed were sufficient to provide a clear basis for its conclusion and the reports utilized a standardized format that sets forth explicitly and separately:	Substantial compliance

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	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.	• Each serious incident or allegations 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. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Sample D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • In 19 of 19 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately o In 19 (100%), each serious incident or allegations of wrongdoing; o In 19 (100%), the name(s) of all witnesses; o In 19 (100%), the name(s) of all alleged victims and perpetrators; o In 19 (100%), the names of all persons interviewed during the investigation; o In 19 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In 19 (100%), all documents reviewed during the investigation; o In 19 (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o In 19 (100%), the investigator's findings; and o In 19 (100%), the investigator's reasons for his/her conclusions.	

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		Facility Investigations The following summarizes the results of the review of Facility investigations: • In six of six investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately o In six (100%), each serious incident or allegations of wrongdoing; o In six (100%), the name(s) of all witnesses; o In six (100%), the name(s) of all alleged victims and perpetrators; o In six (100%), the names of all persons interviewed during the investigation; o In six (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In six (100%), all documents reviewed during the investigation; o In six (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency o In six (100%), the investigator's findings; and o In six (100%), the investigator's reasons for his/her conclusions.	
	(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.	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team does not concur. DSSLC policy CMGMT 01B Incident Management (7/30/10) is intended to address this component of the SA. Based on review of this policy it requires that staff supervising the investigations review each report and other relevant documentation to ensure that: 1) the investigation is complete; and 2) the report is accurate, complete and coherent. The policy also requires that any further inquiries or deficiencies be addressed promptly. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Sample D.2) were reviewed. The results of these reviews are discussed below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. DFPS Investigations The following summarizes the results of the review of DFPS investigations:	Noncompliance

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		• Ten of the 19 (53%) case files reviewed contained evidence that the DFPS supervisor had conducted a review of the investigation report. Those that did not were: 38118497, 38324307, 38587928, 38298061, 38468790, 38409442, 38323204, 38305750, and 38273576. • In all 19 case files, there was evidence that the DSSLC Incident Manager Coordinator had conducted a review of the investigation report and that any concerns had been reported back to DFPS to correct deficiencies or complete further inquiry. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: • In all six investigation files reviewed there was evidence that the supervisor had conducted a review of the investigation report. • In all six, there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. DSSLC uses a form " DSSLC Incident Management Team Review for Incident Investigations and Related Follow-up Action" that documents review of each DFPS investigation report, any issues they may have with the report and follow-up action with DFPS, and concerns either DFPS had identified in the report or the review group identified that require follow-up action on by the Facility. This report becomes part of the official file for each particular incident. In addition, there was an informal review process where the Facility Director and Incident Management Coordinator reviewed each DFPS case independently and more in depth than what occurs at the IMRT meeting. Depending on the case, other executive level staff may also be asked to review the DFPS report. DSSLC would be well served to formalize this process to ensure a small number of senior managers serve as a review group for DFPS case reports. This is probably necessary because the IMRT is a large group which gives attention each day to a large number of issues and relies primarily on verbal representations from the IMC when reviewing DFPS case reports.	Substantial compliance
	(i) Require that whenever	In its Plan of Improvement (POI) the DSSLC reported that it had not as yet achieved	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. DSSLC policy CMGMT 01B Incident Management (7/30/10) is intended to address this component of the SA. This policy requires disciplinary or programmatic action necessary to correct a situation and/or prevent recurrence to be taken promptly and thoroughly. The Facility had a system in place for tracking and documenting such actions. The part of the system that tracks disciplinary action was clear and effective. The part of the system that tracks programmatic action did not appear to be as effective. It was not clear to the Monitoring Team that programmatic actions had expected corresponding outcomes, and that those that did had the expected outcomes tracked. For example, an expected action is often something like "have the PST review this." The outcome that is tracked is typically whether or not the PST met as directed rather than whether they did anything to address the situation and whether or not what they did was effective. The IMC's office is responsible for this tracking and at least in summary form much of these data are reviewed through the incident management review process that is supported primarily by daily unit meetings and the facility-wide daily IMRT meetings. IMRT agendas and minutes generally record and track intended actions until their completion and the expected outcome occurs. In order to achieve compliance with this component the Facility needs to improve the organization of its tracking systems and improve its reporting of outcomes. Case files reviewed by the Monitoring Team included copies of all relevant disciplinary action taken in response to investigation findings.	
	(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.	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. This policy requires the maintenance of investigation files to be easily accessible and to enable an investigator to quickly identify individuals and staff who have been the subject of prior investigations. A database was maintained to facilitate this process and file storage in the IMC's office was organized and up-to-date. The Monitoring Team did not probe whether DFPS had a similar process by which it can quickly access prior history of alleged perpetrators and alleged victims and will need to	Substantial compliance

#	Provision	Assessment of Status	Compliance
		do so in the next review.	
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team does not concur. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. DSSLC produces a monthly Allegations Trend Report and a monthly Unusual Incidents Trend Report. In addition to displaying data for the current report month all data should be displayed for at least a rolling 12 month period in order to detect trends. The data presented in the DSSLC reports do not delineate abuse incidents separate from neglect or exploitation. There is one category for "DFPS cases". Similarly, the outcomes of investigations are not delineated between abuse, neglect, and exploitation. Current month data on the report includes identification 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 investigations. This provides a good snapshot of the current month; however, these data are not trended over time, such as a rolling 12 month period. The Monitoring Team believes they must be in order to achieve compliance with this provision of the SA and to provide the Facility with information it needs to identify issues to address so as to improve safety and services. More detailed data collection is needed to facilitate analysis. For example, DSSLC has one living area which the Monitoring Team's longitudinal data analysis shows was clearly an outlier in several key areas such as allegations, peer to peer injuries, restraint use in general, and restraint use because of aggression to staff in particular. None of the analysis presented on the Trend Reports identified this. This would be an example of how refined data analysis can pinpoint specific issues needing priority attention. The DSSLC has had a Quality Assurance/Quality Improvement Council in place for several months. The Monitoring Team observed a meeting of this group during the review. A report is prepared for presentation at the meeting that includes quantitative monitoring data on several provisions of the SA. This work is organized so each provision of the SA is reviewed quarterly by the QA/QA Council. The Facility had also identified a set of key indicators it believes it should use to track organizational performance over time. Data regarding the key indicators is also reviewed in the QA/QI Council. These reports were presented at the meeting and there was some discussion in some areas, primarily "question and answer" dialogue rather than more substantive "how do we improve" dialogue. As this QA/QI process matures it will be important that it generate	Noncompliance

#	Provision	Assessment of Status	Compliance
		process improvements within the organization.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	In its Plan of Improvement (POI) the DSSLC reported that it had achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/30/10) are intended to address this component of the SA. By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks. In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 25 employees confirmed that their background checks were completed. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to annual fingerprint checks during the month of October, 2010. Once the fingerprints were entered into the system, the Facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. Similar checks were done for a sample of volunteer records reviewed by the monitoring team.	Substantial compliance

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

1. Not all requirements of the SA are reflected in DSSLC policies that govern abuse, neglect, exploitation, and incident management. This needs to be corrected.
2. DSSLC needs to modify its Trend Analysis Report to reflect specific data elements on type of allegations and disposition by type not just for the

current month but over time as occurs with other data elements in the report.
3. DSSLC needs to modify its Trend Analysis Report to report data elements longitudinally.
4. Staff needs additional training on abuse and neglect policy and procedure.
5. The Facility should ensure that statements confirming new employees are aware of their obligation to report abuse, neglect, and exploitation are each signed prior to the date each individual begins working in a direct contact position.
6. The Facility needs to improve the organization of its tracking systems and improve its reporting of outcomes.

The following are offered as additional suggestions to the facility:
1. DSSLC would be well served to formalize a process to ensure a small number of senior managers serve as a review group for DFPS case reports.

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. DSSLC Plan of Improvement 3/15/11 2. DSSLC Section E Presentation Book 3. DADS Policy 003-Quality Enhancement 4. DSSLC Policy CMGMT-15 Quality Enhancement Process, dated 1/5/10 5. DSSLC Draft QA Plan (undated) 6. DSSLC Policy C&C-02 Quality Assurance/Quality Improvement Council 9/29/10 7. Quality Assurance/Quality Improvement Council Meeting: Data Analysis Report 1/6/11, 1/20/11, 2/17/11, and 3/31/11 8. Quality Assurance/Quality Improvement Council meeting minutes 10/21/10, 11/18/10, 1/6/11, 1/20/11, 2/17/11, and 3/31/11 9. Monitoring tools and guidelines for each provision of the SA (various dates) 10. Allegations Trend Report 2/28/11 11. Unusual Incidents Trend Report 2/28/11 12. Restraint Trend Report 2/28/11 **People Interviewed:** 1. Lori Powell, Director of Quality Assurance 2. Frank Padia, Director of Program Coordination 3. Deb Salsman, Director of Incident Management 4. Jeron Dotson, Incident Management Coordinator 5. Sheila Carpenter, SA Coordinator **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 3/28/11 2. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 3/31/11
	Facility Self-Assessment: In its POI the DSSLC reported that it is not yet in compliance with any of the five provisions of Section E of the SA. The monitoring team concurs. The POI reported that systems are in place that will lead to compliance in all five provisions but they all are in need of continued improvement, refinement, and consistent application. From its review the Monitoring Team was able to determine that QA systems are in place and are in various stages of development, refinement, and maturation. The Facility continues to make progress in the development of a QA process that will measure ongoing compliance with the requirements of the SA. A Quality Assurance Plan has not been formalized but the shell reviewed during the last monitoring visit has been expanded and refined. Compliance Reports are routinely prepared and include data that is more representative over time. The workgroups the Facility had established for continued development of operational plans to achieve SA compliance include the

	development of a QA component for each provision.
	Summary of Monitor's Assessment: The Facility continues to make progress in the development of a QA process that is intended to measure ongoing compliance with the requirements of the SA. A Quality Assurance Plan had not been formalized but the shell reviewed during the last monitoring visit had been expanded and refined. Compliance Reports were routinely prepared and included data that were more representative over time. These compliance reports were based on data developed from monitoring tools. A database for the monitoring data had been developed which will facilitate analysis and trends. The workgroups the Facility had established for continued development of operational plans to achieve SA compliance included the development of a QA component for each provision. The Facility had also developed a set of key indicators it used to measure organizational performance. These included overall fill (staff) rates, overall turnover (staff) rates, deaths, deaths from pneumonia, rates of aspiration pneumonia, restraint trends, budget variances, engagement (active treatment) rates, engagement rates by living area, serious injuries, no-serious injuries, abuse/neglect/exploitation confirmations, medication errors, oral hygiene, environmental conditions, community referrals, community placements, and training program compliance. This represents good first attempts at setting up metrics from which organizational performance (and SA compliance) can be measured. A word of caution is in order. The data, particularly observational data, need to accurately reflect performance. For example, engagement data presented to the QA/QI Council reported an 80% or higher level of performance over the last several months. Two members of the Monitoring Team conducted observations and found the engagement level much lower. The QA director presented the Monitoring Team with a set of self-monitoring tools that corresponded to many of the provisions of the Settlement Agreement. Each tool consisted of a set of checklist-type items and had an attached set of instructions for completing each item of the tool. These tools were designed to be used at all of the SSLCs, were generated by DADS central office, and were based upon a set of tools originally used by the Monitoring Teams and developed in 2009. Some tools were slightly modified by DSSLC and the Facility had created a compliance database to record monitoring findings and assess progress over time. At the time of this onsite review, there were tools for 15 of the 20 provisions of the Settlement Agreement. Most provisions had one tool; there were 12 for nursing care and three for most integrated setting practices. Tools were going to be created for the other five provisions. With the exception of minor modifications made by the Facility, these tools used were the Monitoring Team's original tools. It was good to see that tools had been standardized for use by all the SSLCs and that they were based on the Monitoring Teams' original tools. The Monitoring Team, however, recommends that the Facility and state work with the Monitoring Teams to review and update the state-created tools so that they are based upon the most recent findings and activities of the Monitoring Teams.

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E1	Track data with sufficient	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved	Noncompliance

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	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.	substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. The Facility continued to make progress in the development of a QA process that is intended to measure ongoing compliance with the requirements of the SA. A Quality Assurance Plan has not been formalized but the shell reviewed during the last monitoring visit has been expanded and refined. Compliance Reports are routinely prepared and include data that is more representative over time. These compliance reports are based on data reported from various staff that uses the monitoring tools. A data base for the monitoring data has been developed which will facilitate analysis and trends. The Facility had established workgroups for each section of the SA. They are to continue developing operational plans to achieve SA compliance. They are also responsible for the development of a QA component for each provision. The DSSLC has had a Quality Assurance/Quality Improvement Council in place for several months. The Monitoring Team observed a meeting of this group during the review. A report is prepared for presentation at the meeting that includes quantitative monitoring data on several provisions of the SA. This work is organized so each provision of the SA is reviewed quarterly by the QA/QA Council. The Facility had also identified a set of key indicators it believes it should use to track organizational performance over time. Data regarding the key indicators is also reviewed in the QA/QI Council. These include: overall fill (staff) rates, overall turnover (staff) rates, deaths, deaths from pneumonia, rates of aspiration pneumonia, restraint trends, budget variances, engagement (active treatment) rates, engagement rates by living area, serious injuries, no-serious injuries, abuse/neglect/exploitation confirmations, medication errors, oral hygiene, environmental conditions, community referrals, community placements, and training program compliance. This represents good first attempts at setting up metrics from which organizational performance (and SA compliance) can be measured. These reports were presented at the meeting and there was some discussion in some areas, primarily "question and answer" dialogue rather than more substantive "how do we improve" dialogue. As this QA/QI process matures it will be important that it generate process improvements within the organization. A word of caution is in order. The data, particularly observational data, need to accurately reflect performance. For example, engagement data presented to the QA/QI Council reported an 80% or higher level of performance over the last several months. Two members of the Monitoring Team conducted observations and found the engagement level much lower.	

#	Provision	Assessment of Status	Compliance
		DSSLC produced a monthly Allegations Trend Report, a monthly Unusual Incidents Trend Report, and a monthly Restraint Trend Analysis. These reports contained most of the required elements required by the SA for the current report month. Only a limited data set was displayed for a rolling 12 month period, limiting its utility in trend analysis. Most, if not all, data elements should include longitudinal tracking. An example of the value of longitudinal tracking was reported in the finding for Provision D4. DSSLC has one living area which from the Monitoring Team's longitudinal data analysis shows is clearly an outlier in several key areas such as allegations, peer to peer injuries, restraint use in general, and restraint use because of aggression to staff in particular. The Facility did not identify this issue. This would be an example of how refined data analysis can pinpoint specific issues needing priority attention. A significant oversight in the data presented in the DSSLC reports was identified by the Monitoring Team. The reports did not delineate abuse incidents separate from neglect or exploitation. There was one category for "DFPS cases." Similarly, the outcomes of investigations were not delineated between abuse, neglect, and exploitation. Current month data on the report included identification 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 investigations. This provided a good snapshot of the current month; however, these data were not trended over time, such as a rolling 12 month period. The Monitoring Team believes they must be in order to achieve compliance with this provision of the SA and to provide the Facility with information it needs to identify issues to address so as to improve safety and services.. The other trend reports generated by the DSSLC were similarly deficient in presenting rolling 12-month data, which limits their usefulness in fully analyzing trends and targeting administrative and programmatic actions that may be needed to address particular issues, especially systemic issues, in particular locations, at particular times, or with particular staff and individuals. Data presented in these reports included both an overall percentage of items on the monitoring tool in compliance by month over several months and a breakdown of a few items presented only for the current month. There was no way, other than to view the reports from several months individually, to determine whether those measures of specific items were showing improvement or not. The minutes of the QA/QI Council meeting of 3/31/11 reported that one item, which had scored below 80%, was improving, but data over several months did not confirm the improvement. Per interview, it was determined that the DSSLC did not as yet have a fully organized and	

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		operational system for the development, implementation, and tracking of corrective action plans. There were elements in place, such as the follow-up tracking the Incident Management Coordinator did with respect to investigations, the corrective action notices and follow up performed by the Unified Records Coordinator and noted in the findings for Provision V3, and some activity initiated by the Psychology Department and Nursing Department with respect to QA activity they undertake. While this represents some beginning activity the more comprehensive system of corrective action planning contemplated in the SA lies ahead.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. 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. Per interview, it was determined that the DSSLC does not as yet have a fully organized and operational system for the development, implementation, and tracking of corrective action plans. There are elements in place, such as the follow-up tracking the Incident Management Coordinator does with respect to investigations, the corrective action notices and follow up performed by the Unified Records Coordinator, and some activity initiated by the Psychology Department and Nursing Department with respect to QA activity they undertake. While this represents some beginning activity the more comprehensive system of corrective action planning contemplated in the SA lies ahead. 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 are developed and tracked. Most of the data reviewed by the QA/QI Council comes from the monitoring tools that are used for each provision of the SA. Much of the variability in the monitoring tools, including appearance, content, and frequency of use, sample size, and monitoring assignments noted in the last compliance review had been corrected. There are still a	Noncompliance

#	Provision	Assessment of Status	Compliance
		number of features of this process that can best be characterized as "a work in progress" and the facility administration recognizes they have just started a process of QA that will take a considerable period of time to mature. DSSLC made a significant improvement by creating guidelines for each of the monitoring tools. This should facilitate greater consistency among those doing the monitoring. Additionally, at least for some monitoring tools, the Facility had begun inter-rater reliability checks, which should also improve, over time, the efficacy of data resulting from use of the monitoring tools. There are still several improvements needed in the overall design of the monitoring system. Data items on the monitoring tools have not been weighted so in preparing overall compliance reports the most critical data item counts the same as the most mundane. Additional steps need to be taken to ensure monitors/reviewers who do not have specific subject matter expertise have adequate training and support 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 observed during this monitoring visit demonstrated continued improvement in the development and implementation of a sound QA system. 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 continue to refine its key indicators and outcome measures. Simple analysis that "we're trending up" or "we're trending down" is not sufficient. Data analysis also needs to be sufficiently robust to 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. 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.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. Per interview, it was determined that the DSSLC did not as yet have a fully organized and operational system for the development, dissemination, implementation, and tracking of	Noncompliance

#	Provision	Assessment of Status	Compliance
		corrective action plans. There were elements in place, such as the follow-up tracking the Incident Management Coordinator does with respect to investigations, the corrective action notices and follow up performed by the Unified Records Coordinator, and some activity initiated by the Psychology Department and Nursing Department with respect to QA activity they undertake. While this represents some beginning activity the more comprehensive system of corrective action planning, including dissemination of corrective action plans, contemplated in the SA lies ahead. Each provision of the SA had 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, including dissemination of corrective action plans and monitoring of followup and effectiveness of actions taken, during this review (with the exception of the Recordkeeping audit corrective actions, which focused on individual records but had not yet addressed systemwide trends). The Quality Assurance Director referred to the system of corrective action planning as a work in progress. The Monitoring Team looks forward to future reviews of this provision.	
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.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. Per interview, it was determined that the DSSLC did not as yet have a fully organized and operational system for the development, implementation, and tracking of corrective action plans. There were elements in place, such as the follow-up tracking the Incident Management Coordinator does with respect to investigations, the corrective action notices and follow up performed by the Unified Records Coordinator, and some activity initiated by the Psychology Department and Nursing Department with respect to QA activity they undertake. While this represents some beginning activity the more comprehensive system of corrective action planning contemplated in the SA lies ahead. For example, the Facility had developed a database that provided an at-a-glance picture of the status of completion of corrective actions required as a result of audits of records. The database, which would be useful in ensuring all corrective actions are completed, did not provide information to track and trend the types of items requiring corrective action, the individuals or disciplines responsible for making the corrections, or the timeliness of corrections. Therefore, while useful for ensuring individual corrective actions are completed, it would not lend itself to identifying and following up on systemic	Noncompliance

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		corrections needed and made. 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 (with the exception of the Recordkeeping audit corrective actions, which focused on individual records but had not yet addressed systemwide trends). The Quality Assurance Director referred to the system of corrective action planning as a work in progress. The Monitoring Team looks forward to future reviews of this provision.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. Per interview, it was determined that the DSSLC did not as yet have a fully organized and operational system for the development, implementation, and tracking of corrective action plans. There were elements in place, such as the follow-up tracking the Incident Management Coordinator does with respect to investigations, the corrective action notices and follow up performed by the Unified Records Coordinator, and some activity initiated by the Psychology Department and Nursing Department with respect to QA activity they undertake. While this represents some beginning activity the more comprehensive system of corrective action planning contemplated in the SA lies ahead. 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 (with the exception of the Recordkeeping audit corrective actions, which focused on individual records but had not yet addressed systemwide trends). The Quality Assurance Director referred to the system of corrective action planning as a work in progress. The Monitoring Team looks forward to future reviews of this provision.	Noncompliance

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

1. Continue efforts to develop the quality assurance plan, including refining key indicators and outcomes. Review and update the state-created tools so that they are based upon the most recent findings and activities of the Monitoring Teams.
2. Expand the data reported in Trend Reports to display more longitudinal data and to appropriately delineate subcategories, such as type of abuse.
3. Ensure subject matter content experts are available to validate that DSSLC auditors/monitors using each tool have sufficient knowledge from which to assess data items on each tool.
4. Develop a system of "weighting" data items on monitoring tools, where appropriate.
5. Use 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.
6. 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 (POI), dated 3/15/11 2. DSSLC Section F Presentation Book (undated) 3. DADS Policy 004 Personal Support Plan Process 7/30/10 4. DSSLC Policy CMGT-12.01 Personal Support Planning Process 1/3/11 5. PSPs for Individuals #299, #503, #68, #197, #295, #432, #458, #579, #606, #621, #645, and #687 6. PSP meeting Monitoring Checklist for individuals # 293 (3/30/11), #299 (2/28/11), 742 (3/3/11), #487 (3/23/11), #725 (11/9/10), #210 (11/15/10), #81 (1/25/11), #226 (2/3/11), #669 (2/8/11), #691 (3/28/11) #772, and #713 (2/17/11) 7. PSP document auditing for Individuals #123, #311, #618, #763, #619, and #729 8. PSP Packet Tracking (undated) 9. PSP Assessments Tracking 3/30/11 10. PSP Attendance Tracking 1/11 11. PSP signature sheets for Individuals #295, #720, #8, #755, #606, #408, #565, #172, #366, #221, #13, #307, #507, and #726 12. Personal Focus Assessments (PFA) for Individuals #37, #68, #121, #149, #197, #216, #222, #239, #270, #293, #295, #317, #362, #383, #385, #395, #413, #432, #458, #530, #545, #579, #606, #645, #687, #691, #730 13. Q Audit forms for Individuals #68, #587 **People Interviewed:** 1. Lori Powell, 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. Sheila Carpenter, SA Coordinator 7. Ken Horstman, Director of Residential Services **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 3/28/11 2. Restraint Reduction Committee 3/30/11 3. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 3/31/11 4. PSP Meeting for Individuals #691, #772, and #293 5. Personal Focus Assessment meeting for Individuals #557 and #572
	Facility Self-Assessment: In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance any of the provisions of this section of the Settlement Agreement. The

	Monitoring Team concurs. The facility recently (1/3/11) updated its policy on PSP planning and has improved some aspects of the PSP process. Many of the things noted by the Monitoring Team as an improved practice were situational and not observed in enough instances and implemented with enough consistency to conclude that generalized improvement throughout the facility had occurred.
	Summary of Monitor's Assessment: Interdisciplinary planning is more than the development of an annual plan at an annual meeting that involves reports from several disciplines. It requires integrated decision-making in which the information provided by several disciplines serves as the basis for discussion by all members of the interdisciplinary team. It also involves integrated discussion and decision-making whenever decisions about treatment and care are being made. Although the structure of an interdisciplinary team is in place at DSSLC, much of the discussion remained multidisciplinary, and decisions about treatment were too often made in the absence of team discussion. The new PSP planning process had been initiated, and most staff had received training. Many PST members were having difficulty understanding the concept of providing integrated services and the need for a comprehensive PSP that describes the individual's strengths and abilities, and then translating this understanding to a functional and meaningful program of services and supports. Nevertheless, most staff encountered by the Monitoring Team reported and demonstrated they embraced the general concept of integrated planning and were eager to learn how to make it work. PSTs did attempt to discover and meet the preferences and needs of individuals; however, they seldom used a fully interdisciplinary process that resulted in an integrated approach to life planning with the individual. Staff who were needed because of specific areas of concern or support for individuals was not always present at planning meetings. As a way to identify preferences, the Facility had begun to implement the new Personal Focus Assessment (PFA). The goal of this new process was to ensure that individuals' preferences formed the basis for the goals, objectives, anticipated outcomes, services, supports, and treatments of the individual's own PSP. The process was not yet conducted with sufficient quality to reliably identify the individual's strengths, preferences and needs.

#	Provision	Assessment of Status	Compliance
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:	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. DSSLC Policy CMGT-12.01 Personal Support Planning Process (1/3/11) is intended to establish administrative requirements sufficient to ensure compliance with this	Noncompliance

		provision of the SA. Although the structure of an interdisciplinary team process was in place, most involvement is multidisciplinary. From document review and meeting observation it was evident that different disciplines did separate assessments and decision-making, reporting information and decisions, but not routinely integrating information to make joint or shared decisions. The new PSP planning process had been initiated, and most staff had received training.	
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. Each PSP planning session was facilitated by one person, the Qualified Mental Retardation Professional (QMRP). This is the position in the Facility organization who is responsible for ensuring the PSP is developed, monitored, and revised as needed. This is an area in which the State and the Facility have self-identified the need for additional staff training. The QMRPs were not proficient at facilitating a meeting or developing an effective and integrated PSP, as is evidenced throughout this section and others. It was reported by the Director of Program Coordination that key staff members, including himself and the QMRP Educator, would be attending facilitation training in Austin in April and would subsequently provide that training to the QMRPs at the Facility. This was a much needed action. For this provision to be in compliance, not only does the PSP process need to be facilitated by one person, but also team members must participate in assessing each individual and in developing, monitoring, and revising treatments, services, and supports as necessary throughout the year. This did not always occur, as indicated by the following examples: • Provision K5 reports that intellectual and adaptive behavior assessments were not routinely provided as needed. • Provision R1 reports many records that indicated no participation by the SLP in the PSP process outside of providing the required assessments. This resulted in communication issues being discussed without the presence of the SLP. This provision also provides examples in which supports designed to improve or augment existing language were not provided.	Noncompliance
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs.	Noncompliance

	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 teams ordinarily consisted of the individual and/or LAR or a family member who does not have guardianship, clinicians representing specific services, the QMRP, and direct care staff. The Facility had implemented the new Personal Focus Assessment (PFA), which was intended to ensure the PSP would be centered on the needs, preferences and personal goals of the individual. This requires that the participants in the PFA be the individual as well as those people who have close relationships with the individual and those who have knowledge of important preferences, goals and events in the individual's life. For one PFA held during the week of the site visit for Individual #557, the individual attended the PFA meeting. The individual's mother was conferenced in by telephone, but she was often unable to hear or otherwise participate, and the other participants did not take great pains to facilitate her involvement. At one point, the PST suggested that someone could call her back after the meeting and tell her what happened, and she hung up. The individual's mother is very involved and the relationship is of utmost importance to the individual. It was not appropriate to hold a PFA meeting that did not effectively facilitate her participation. Other key members of the individual's team were also not present. This became evident as the meeting proceeded. The RN stated toward the end of the meeting that she forgot to mention that Physical Therapy had begun working with the individual on getting out of his wheelchair and walking. It was also mentioned that the individual was being assessed for use of a motorized wheelchair, but none of t he meeting participants were aware of the status. It was also noted that the individual very recently had a swallow study and had started a regular diet, which was an upgraded texture from ground. These were all significant events/issues, but neither Occupational Therapy nor Physical Therapy were represented at this PFA meeting, which is intended to form the basis for the upcoming year. For the other PFA for Individual #572, the individual and mother were present. The issue of preferences was one of many topics (with the initial focus being on the psychotropic and antiseizure medications). Even during discussion of preferences, the focus was on preferred activities, with no discussion of a vision for future living. The PFA, particularly as it is currently implemented should not be seen as a singular vehicle for preparing an individual to participate in his or her own planning in a meaningful way and to envisioning his or her future. Although individuals typically attend the PFA and PSP meetings, their actual participation is often very limited. Individuals with intellectual disabilities will benefit from repeated and ongoing experiential activities in this area, as with many others, as opposed to once or twice a year. The State and Facility should consider how they might expand on the PFA process to be an ongoing process that truly supports individuals to be active participants in their own planning. The Monitoring Team recommends that the Facility implement a formal curriculum for "planning my future" that is incorporated into the overall active treatment program on an ongoing and regular basis. Information regarding person-centered	

		training models that might assist QMRPs to better facilitate this process may be found at: http://www.ilr.cornell.edu/edi/pcp/courses.html. DSSLC maintained a PSP Attendance Tracking log which identifies, by discipline, staff that attend PSP and PSPA meetings. A review of this log by the monitoring team suggests that for the most part appropriate staff attended the PSP and PSPA meetings with the exception of direct care professionals (DCPs). In reviewing the first 40 PSP/PSPA meetings on the attendance log DCPs were only noted as being present 48% (19) of the time. In only one instance were more than one DCP present. At least one, preferably two,DCPs representing different shifts, should be present at PSP meetings to provide information that would be known by someone who works daily with an individual. Other disciplines also did not always participate as needed or required, For example, per interview with the Communication Director, SLPs still did not participate in the PSPs for individuals with severe or moderate speech deficits outside of Cedar Falls. This was a result of not having enough therapists.	
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.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. As a way to identify preferences, the Facility had begun to implement the new PFA in December 2010. Prior to that time, the Facility used the Personal Focus Worksheet to obtain information regarding personal goals and preferences to be used to develop a person-centered plan. The goal of this new process was to ensure that individuals' preferences formed the basis for the goals, objectives, anticipated outcomes, services, supports, and treatments of the individual's own PSP. The PFA is completed at the time of the third quarterly review. A review of four PFAs and attendance at a portion of the single PFA meeting held during the week of the site visit indicated the process was not yet conducted with sufficient quality to reliably identify the individual's strengths, preferences and needs. Four of the four PFAs (100%) were incomplete, with many questions and even whole sections left blank. Based on a review of 19 individual records, documentation supported that the PNM 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 Team or PST did not meet regularly to address change in status included: • Individual #245 developed aspiration pneumonia on 10/26/10 but there was no evidence that the PNMT or PST met to discuss to discuss the aspiration post hospitalization. • Individuals #131 and #548 had a modified barium swallow study conducted on 12/21/2010. There was no evidence that the PST or PNMT met to discuss the	Noncompliance

findings of the test and determine if there was a need to revise the current plan of care

- Individual #537 had a choking event occur on 1/14/2011 post visit to have teeth extracted. There was no evidence of discussion prior to return to home regarding whether diet texture should be temporarily modified. Additionally, there was no evidence that the PST met to discuss findings of a meal observation that occurred on 1/14/11
- Individual # 761 had a choking event on 11/15/10 but there was no evidence of PNMT or PST discussion or evaluation of the event outside of the incident report.
- Individual # 419 developed aspiration pneumonia on 11/5/10. The team met to discuss the hospitalization but there was no evidence that the PNMT or PST met to discuss the findings of the MBSS that was conducted on 11/18/10
- Individual #699 developed aspiration pneumonia on 12/10/2010 but there was no evidence that the PNMT or PST met to discuss issues until the PSP meeting on 1/14/11. The PST did not meet post hospitalization to discuss the aspiration event.

There were similar examples in the area of behavioral services. For example, for Individual #367, target behaviors began increasing in June 2010 and, with the exception of August, remained substantially elevated through the end of 2010. Despite data that indicated worsening undesired behavior, progress notes provided no information about any specific anticipated benefit from continuing the existing PBSP. Furthermore, no recommendations were made to revise the PBSP or explore the lack of treatment efficacy. In January of 2011, however, when displays of target behaviors dropped to near zero, the recommendation was made to revise the PBSP. Although data suggested the PBSP was ineffective, a revision to the PBSP would have provided greater potential benefit had revisions been introduced in a more timely manner.

Assessments required for the annual PSP planning meeting were frequently not done on time. The Facility has an expectation that professional assessments be completed two weeks prior to the date of the PSP meeting. This is to ensure that assessments can be placed in appropriate folders in a shared drive within 10 working days of the meeting. This is required by DSSLC Policy CMGMT 12.01 and is necessary so that PST members can review each other's assessments prior to the PSP planning meeting. This pre-meeting independent review is intended to facilitate integrated discussion and planning at the meeting. Assessments often did not meet this policy-required timeframe and too frequently were not available to team members until they arrive at the meeting. In some cases they were not available, in written form until after the PSP meeting. The Monitoring Team reviewed the PSP Assessment Tracking log for eight individuals (3567, #594, #571, #713, #782, #339, #391, and #335) for February, 2011 PSP meetings. The log identified 53 needed assessments. Six (11%) were presented at the meeting. Eight (15%) were not available until after the meeting. Ten (19%) were available before the

		meeting but after the policy required due date raising doubt as to their usefulness in PSP planning meeting preparation. Twenty-four (45%) were not available within a timeframe that would facilitate integrated discussion and planning. These 24 late assessments consisted of: Six of eight (75%) Medical/Physician Six of eight (75%) Nursing One of eight (13%) Dental Six of eight (75%) Adapted Equipment/PME One of eight (13%) Nutrition Two of eight (25%) Psychology Two of eight (25%) Life Skills One of the eight (13%) PSPs (Individual #713) met all policy requirements associated with the preparation of assessments. As a way to identify preferences, the Facility had begun to implement the new PFA in December 2010. Prior to that time, the Facility used the Personal Focus Worksheet to obtain information regarding personal goals and preferences to be used to develop a person-centered plan. The goal of this new process was to ensure that individuals' preferences formed the basis for the goals, objectives, anticipated outcomes, services, supports, and treatments of the individual's own PSP. The PFA was to be completed at the time of the third quarterly review, in order that the identified preferences could be used by the various disciplines in focusing their assessments. A review of 28 PFAs and attendance at one PFA meeting held during the week of the site visit indicated the process was not yet conducted with sufficient quality to reliably identify the individual's strengths, preferences and needs. Many of the PFAs were incomplete, with many questions and even whole sections left blank. The Facility was attempting to incorporate the PFA/third quarterly meeting with the Psychiatry Clinic review for those individuals who receive psychotropic medications. While the monitoring team appreciated the desire of the Facility to better integrate psychiatry services with the overall PSP process, the Psychiatry Clinic process was incompatible with the intent of the PFA to focus on individuals' personal goals and preferences. The PFAs observed in this setting began with a recitation of the individual's target behaviors, psychiatric symptoms and psychotropic medications. One PFA observed was completed in a rote manner, with questions being framed in ways that were not meaningful to the individual. In addition to failing to complete annual assessments and the PFA as needed, the Facility did not always conduct comprehensive assessments routinely and in response to	

		significant changes in the individual's life. For example, based on a review of 19 individual records, documentation supported that the PNM 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 Team or PST did not meet regularly to address change in status included: • Individual #245 developed aspiration pneumonia on 10/26/10 but there was no evidence that the PNMT or PST met to discuss to discuss the aspiration post hospitalization. • Individuals #131 and #548 had a modified barium swallow study conducted on 12/21/2010. There was no evidence that the PST or PNMT met to discuss the findings of the test and determine if there was a need to revise the current plan of care • Individual #537 had a choking event occur on 1/14/2011 post visit to have teeth extracted. There was no evidence of discussion prior to return to home regarding whether diet texture should be temporarily modified. Additionally, there was no evidence that the PST met to discuss findings of a meal observation that occurred on 1/14/11 • Individual # 761 had a choking event on 11/15/10 but there was no evidence of PNMT or PST discussion or evaluation of the event outside of the incident report. • Individual # 419 developed aspiration pneumonia on 11/5/10. The team met to discuss the hospitalization but there was no evidence that the PNMT or PST met to discuss the findings of the MBSS that was conducted on 11/18/10 • Individual #699 developed aspiration pneumonia on 12/10/2010 but there was no evidence that the PNMT or PST met to discuss issues until the PSP meeting on 1/14/11. The PST did not meet post hospitalization to discuss the aspiration event.	
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.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. As described in F1c above, the Facility did not ensure that assessments were completed on a timely basis. The assessments were not available for the PST to review prior to the PSP meeting, as current policy calls for, nor were the assessments reviewed in the PSP meeting itself, as was the prior practice. Therefore, there was no consistent approach to ensuring the PST was familiar enough with assessment results to use them effectively in the development of a PSP that outlines the protections, services, and supports to be provided to an individual. The Monitoring Team requested the list of PSPs to be held in the week following the compliance site visit, and reviewed the assessments available in	Noncompliance

		the O drive for six of the eleven upcoming PSPs. The S drive was also accessed, as it was reported that some staff may not have made the transition to the O drive. For six of six assessment packets, there were many missing assessments. Examples included: • For Individual #222, missing assessments included Psychology, Audiology, OT, PT, Communication and Vocational. • For Individual #730, missing assessments included Psychology, Audiology, Communication, Nursing, Medical, Nutrition and Dental. The only assessments available were OT, PT. Vocational and Pharmacy. • For Individual #37, missing assessments included Psychology, Audiology, Medical, OT, PT, and Communication. For four of the six assessment packets reviewed, the PFA was also missing or essentially devoid of any information. As the PFA is supposed to drive the development of the rest of the assessments and the PSP as a whole, its absence was particularly troubling. Without adequate information in the PFA to refer to, even the assessments that were available prior to the meeting could not be expected to adequately reflect the individual's preferences. Before the site visit was complete, the Monitoring Team received a PFA for this year's annual planning meeting for all but one of the individuals scheduled for a PSP the following week. Three were dated 3/30/11 and several were undated and/or still in handwritten form, therefore they were unavailable to provide guidance t othe overall assessment process. Many were very incomplete and lacking in specificity about the individual's preferences. This failure to consistently implement the prescribed PFA process was borne out by additional examples: • For seven of the ten recent PSPs reviewed, the PFA was held ten days or less before the PSP. For four of these, the PFA was documented as having occurred the same day as the PSP, while a fifth PFA was held the day before the PSP meeting. For five of the seven PSPs (71%) held during the week of the monitoring visit, it was also apparent the PFA was not routinely being completed as required. Only three were completed well in advance of the PSP meeting, and two of these had significant portions that were blank or were noted as "no indication." Another one was dated 3/25/11 for a PSP to be held on 3/29/11. A fifth PFA was undated, but the QMRP stated at the PSP meeting on 3/28/11 that the team had met the previous Friday (3/25/11) to consider the individual's preferences. The sixth PFA was undated and still in handwritten form. The seventh was not completed.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. §	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs.	Noncompliance

	12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	While DADS policy and the SA explicitly state that the decision of the LAR regarding community placement is to be honored, the ADA and Olmstead decision call for a person to be served in the most integrated setting appropriate to their needs as determined by qualified professionals unless the individual (or LAR) specifically objects. The Monitoring Team attended three PSPs and reviewed ten PSPs completed since the new process began in 10/10, as measures of how this new process may have affected the PSTs' implementation of this requirement of the SA. For three of three PSPs (100%) observed during the monitoring visit, and for seven of ten PSPs reviewed (70%), the PST failed to adequately consider and provide an assessment, by qualified professionals, of the most integrated setting appropriate for the person. The PSP Meeting Monitoring Checklist included item #14 that asks, "Did PST determine individual and or LAR preference for placement?" as well as questions about LAR awareness of living options and plans for improving awareness, but it did not include an item asking whether professionals made a determination of appropriateness for a more integrated setting. Examples of observations from PSP planning meetings include: • For Individual #772, the LAR clearly stated opposition to community placement. The professionals on the PST did not discuss or provide a determination of appropriateness for referral to a more integrated setting, nor did the MRA. The QMRP Coordinator, who was mentoring at this meeting, did ask the LRA what supports would be needed, and the Mental Retardation Authority (MRA) staff told the LAR that she could be called at any time to explore options. The PSTs largely deferred their own assessment of the most integrated setting appropriate for the individual in light of the guardians' or family's opposition to community placement or preference for the individual to remain living at the Facility. There were only two PSPs reviewed, for Individuals #432 and #458, in which the team found that community living would be the appropriate most integrated setting. Neither of these individuals had guardians. For the only other individual in the sample who did not have a guardian (Individual #68), the team stated it believed the individual would do well in a smaller setting out in the community, but wanted to seek a guardian to help with making decisions before making a referral. This is of concern since all of the other seven individuals had a guardian or family member who did not want the individual to be considered for community living and the team had acquiesced to that preference. On occasion, the teams constructed a justification for recommending that DSSLC was the most integrated setting based on a profile of support needs of individuals that were essentially the same as the profile of the individuals who did not have guardians and were referred. An example follows: For Individual #621, an individual with a guardian who is opposed to community placement, the PST found that DSSLC was the most integrated environment. According to the PST, Individual #621's medical and health care	

		needs were obstacles and factors that contributed to the decision of most integrated setting. These included that the individual used a large wheelchair and a special hospital bed, had osteoporosis and a history of fractures, was diabetic and required a special diet and diet texture. The individual was at high risk for aspiration, osteoporosis, and urinary tract infections. Yet, Individual #432, a person without a guardian, was referred for community living, even though this individual had very similar needs. The individual used a wheelchair and a special hospital bed with a bed monitor. The individual was identified as being at risk for choking, aspiration, respiratory compromise and osteoporosis. The individual required a pureed diet and complete assistance to eat. In addition, the individual displays physical aggression to others and has a Positive Behavior Support Plan.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. DSSLC Policy CMGT-12.01 Personal Support Planning Process (1/3/11) is intended to establish administrative requirements sufficient to ensure compliance with this provision of the SA.	Noncompliance
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:	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs.	Noncompliance
	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;	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. As discussed throughout this Section F, the PSTs had not been consistently completing the PFA in such a manner that they could be said to have a full understanding of the individual's preferences and strengths. Thus, it is not feasible that a plan developed without this understanding could address the individual's needs in a manner that built upon those preferences and strengths. For three of three PSPs attended by the Monitoring Team, the PST did not sufficiently address barriers to community living, as detailed in section T1b, nor was community participation sufficiently encouraged.	Noncompliance

	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;	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. For three of three PSPs attended by the Monitoring Team, the PSTs failed to adequately develop individualized goals and action plans related to living in the most integrated setting. A review of ten recently completed PSPs confirmed that assessment. See T1b for additional detail.	Noncompliance
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. Timely and accurate assessments are foundational to the development of integrated protections, services and supports, treatment plans, clinical care plans, and other interventions provided for each individual As described in F1c, assessments required for the PSP meeting are frequently not done on time so that PST members can review each other's assessments prior to the PSP meeting. This pre-meeting independent review is intended to facilitate integrated discussion and planning at the meeting. For example, PSPs contained reference or a brief statement of an individual's communication skills but did not provide integration of the utilized devices or strategies into existing action plans resulting in a decreased opportunity for generalization and/or acquisition of skills.	Noncompliance
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. For example, interventions specified in PBSPs, even for individuals who were experiencing restraint, did not specify a schedule for training, the number of trials per training session, or a procedure for reinforcing desired responses. They did not specify treatment expectations and timeframes for achieving those expectations. Also, PNMPs did not include strategies for medication administration or oral hygiene.	Noncompliance
	5. Provides interventions, strategies, and supports that effectively address the	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs.	Noncompliance

	individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	The PST did not consistently provide in the PSP for interventions, strategies, and supports that effectively address the individual's needs for services and supports that are practical and functional at the Facility and in community settings. Examples included: • For Individual #295, the PST found that the individual's overall vision was to get a higher paying job in the community, and also noted that he appeared to be interested in community activities. The team stated they were concerned for the individual's safety if he lived in the community because he is independent and likes to walk about the neighborhood, but has few pedestrian skills. The team did not develop any strategies for exposing him to learning opportunities about living options, nor community employment. The only strategy developed for the obstacle of pedestrian safety was a training program that consisted of prompting him to stop at the crosswalk when going to evening activities on campus, rather than training that would allow him to learn pedestrian safety in a community setting. • For Individual #687, the PST identified a lack of generalized pedestrian skills off-campus although on-campus pedestrian skills were described as good. No strategies were developed by the team to address this issue in the community, although the individual had many preferences related to community integration, such as shopping, dining out and community excursions.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. In February of 2011, a new data collection system was implemented. This system made use of a standard form for recording data that could accommodate frequency counts, as well as duration, interval and accuracy measures. This new data collection process allowed for much greater flexibility in data collection, but also introduced potentially problematic constraints. However, it was very new, and it was not yet used broadly enough to establish compliance. Data for skill acquisition programs were not graphed, nor were summaries of progress adequate to determine whether interventions were effective in addressing the individual's needs. It was also not clear from available progress notes that individuals had strengthened existing behaviors or developed new skills because of skill acquisition programs. Instructions and definitions for data to be taken for PBSPs were often unclear and vague, as noted in Section K.	Noncompliance

		While PNMPs are reviewed at the PSP, there was not a system fully in place that clearly monitored the effectiveness of the plan by tracking clinical indicators for all individuals who are determined to be at a high risk such as the occurrence or absence of triggers (signs and symptoms associated with physical and nutritional decline that require staff response). The Aspiration Trigger data Sheet designed to monitor the presence or absence of triggers related to potential aspiration was in the process of being implemented for the individuals who were on the target list. In addition to the introduction of new data collection procedures, DSSLC also implemented the first phase of a process to measure interobserver agreement (IOA) for PBSC data. As the IOA procedure was implemented only a few weeks prior to the site visit, it was not possible to develop a clear measure of whether efforts at collecting IOA data were successful. Nevertheless, the effort to determine the reliability of treatment data was welcomed by the Monitoring Team.	
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.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. As documented in examples found in several sections of this Report, there is a lack of coordination in the PSPs among the goals, objectives, anticipated outcomes, services, supports, and treatments. For example, there were few examples in which more than one goal was developed to provide an integrated approach to meeting a desired outcome. The Monitoring Team found that there was good collaboration at DSSLC across disciplines, and that behavioral data was considered in decisions regarding pharmacological treatments. However, the Monitoring Team found that the overall process remained multidisciplinary rather than interdisciplinary. That is, the Monitoring Team found deficiencies in the process that brought together information from different disciplines; information was presented and disciplines worked together but did not jointly formulate plans to address the same goals.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. Seven of ten direct care professionals (70%) indicated the PSP was written in a manner that was understandable to them and they found the document useful in knowing what their responsibilities were with respect to individuals under their care. The other three staff indicated the PSP was written in a manner that was understandable to them but were unable to provide any examples of how the document was of assistance to them in	Noncompliance

		understanding things about the individual and carrying out their daily responsibilities. The purpose of a PSP being "accessible and comprehensible" to staff is to ensure staff have the necessary information to implement the PSP. If Direct Care Professionals are unable to articulate examples of how the PSP was of assistance to them in understanding things about the individual and carrying out their daily responsibilities it is doubtful that the document was "comprehensible," at least to that particular staff person. Staff reported they were able to find PSPs and necessary information in the Active Record and individual notebook. Nevertheless, staff was, at times, not familiar with the contents of the PSP. For example: • DCPs interviewed were not knowledgeable of the communication programs. • As noted in Provision P3, staff did not implement PSPs accurately. • As reported in Provision S3, observations documented little activity in both homes and day programs. There was no evidence that the PSPs guided staff actions to engage individuals.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. For the most part, PST members responsible for each service or support documented review monthly. There were, however, numerous instances in which either that documentation was not available or there was no change in the service or support although documentation indicated lack of progress over an extended time without action being taken by the PST; examples can be found in Section K in which lack of expected progress did not trigger revisions in services, and in Section O in which change of status related to aspiration did not result in further assessment and intervention.	Noncompliance
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. To be in compliance with this component the facility must demonstrate that the initial training provided to new employees, and refreshers at 12 month intervals, is competency based, and that every employee has completed the training.	Noncompliance

	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.	From information reported at the review entrance meeting DSSLC reported it had provided training on a new PSP process to 1739 staff. The training curriculum was reviewed. There was not a competency evaluation component. This training was primarily an introduction to the new PSP process and the Supporting Visions curriculum. Although this training was a good beginning, a considerable amount of additional training that focuses on operationalizing the principles' presented in the introductory training is needed. For example, It was clear from the review of the PFA process, as described above in this Section, that the staff responsible for the development of individuals' PSPs were not competent in the implementation of the PFA. As it was intended to form the foundation for the PSP, this also spoke to the competency of the staff in the development of that plan. Following the PFA meeting for Individual #55, the Monitoring Team briefly interviewed the individual's QMRP, who stated there had been little training in the PFA process. Additionally, the facility must also be able to demonstrate that individual staff members responsible for working with a particular individual have received competency based training on the implementation of that specific individual's program plan, and additional competency based training whenever that plan is revised. DSSLC CMGMT 12.01 addresses this SA requirement in section IV.B.1, 2, and 3. Specifically, IV.B.2 states "professional staff or designee is responsible for providing competency-based training (CBT) to staff responsible for implementation of the PSP. The QMRP is responsible for providing CBT to all new and existing staff responsible for implementing the PSP. The Building Coordinator will assist the QMRP with staff training as necessary." How training on an individual's PSP is to be accomplished per this policy is unclear. This policy suggests that each staff person be trained by the QMRP and by the professional staff, and, maybe also by the Building Coordinator. In all likelihood, the intent was that certain parts of the PSP implementation are to be trained by discipline specific staff (e.g. Psychologist or nurse) and other parts of PSP implementation are to be trained by the QMRP or Building Coordinator (e.g. skill acquisition programs). For example, the implementation steps associated with a PBSP are probably going to be trained by the psychologist who developed the plan and the trainees are likely to be not just direct support staff but also the individuals QMRP, building supervisory and nursing staff, day program staff, and others who may regularly interact with the individual including family members. This policy, or some other document, should provide much more detailed information and specification as to how training associated with PSP implementation for specific individual PSPs is expected to occur. The definition of competency-based training in the SA reads "…the provision of	

		knowledge and skills sufficient to enable the trained person to meet specified standards of performance as validated through the persons' demonstration that he or she can use such knowledge or skills effectively in the circumstances for which they are required." The monitoring team believes that competent staff performance, on the job, is the critical variable in determining compliance with this component of the SA. There are numerous examples throughout this monitoring report of staff not adhering to policy, not engaging individuals (active treatment), not intervening appropriately in behavioral issues, and not intervening appropriately at mealtime which suggests much improvement is needed in training curricula, training delivery, or competency testing, or, all three.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. PSP dates were reviewed for a sample of 14 individuals. Thirteen (93%) of the PSPs were held within one year of the prior PSP. Individual #720 PSP meeting was 2/10/11. The prior year's PSP meeting was 2/3/10. PSPs are not always put into full effect within 30 days. For example, in a review of the PSP for Individual #12, only 10 of 17 (59%) implementation steps reviewed by the Monitoring Team were put into effect within thirty days of the PSP meeting. DSSLC policy requires that all service objectives be implemented with 14 calendar days.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. Beginning in January, 2011, the Facility had designated a PSP workgroup to assess the process on the new person-centered planning process. The group was tasked to assess and assist PSTs in facilitating annual meetings. The Facility used the Personal Support Plan Meeting Monitoring Checklist as a quality assurance tool to identify and remediate problems to ensure PSPs are developed and implemented consistent with the provisions of section F of the SA. The completed checklists reviewed by the Monitoring Team and summary reports prepared by the QA Department did not reveal the scope or number of issues the Monitoring Team observed in PSP meetings attended. This suggests more rigorous training of monitors, and more rigorous monitoring, is needed to achieve compliance with this component of the SA. Examples included: • For Individual #691, the PSP Monitoring Checklist indicated the meeting began with a review of preferences identified at the PFA meeting. This would have appeared to indicate this process was completed in accordance with the	Noncompliance

		requirements of the PSP policy; however, it was noted at the meeting that the meeting to discuss preferences was only held on the Friday before this Monday meeting, and the PFA contained minimal information, with most of the document left blank. • For Individual #691, the PSP Monitoring Checklist also indicated the PST discussed the person's need for an advocate or guardian, but there was no significant discussion about the individual's specific needs in this area. In addition to the Personal Support Plan Meeting Monitoring Checklist, the QMRPs had performed a number of record reviews using the Q Audit form. The form instructions note that the PST must meet to address any item under the PSP Review section marked "No." This was not consistently implemented by the Facility. Examples include: • For a Q Audit for Individual #587 on 2/25/11, two items were marked "No," including whether the PSP documented a Vision for Living Options for the individual. The only PSP addendum meeting documented after that date was on 03-28-11 and did not address this subject. • For Individual #68, the Q Audit indicated the PSP did not adequately identify prioritized goals and that there was a need to add a desired outcome to each of those. One PSP Addendum meeting had been held on 03-28-11, but it only addressed purchase of new bedroom furniture.	

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

1. Fully implement DADS policy on PSP planning, including the PFA.
2. In order to support meaningful involvement and participation by individuals in their own planning, the Monitoring Team recommends that the Facility implement a formal curriculum for "planning my future" that is incorporated into the overall active treatment program on an ongoing and regular basis.
3. Improve methods for data collection, tabulation, and use for all program plans.
4. Review the assessment process to ensure individuals receive timely and necessary assessments and reassessments as their circumstances change.
5. PSTs should receive additional instruction as to their responsibilities to complete a professional assessment of the most integrated setting appropriate to each individual per the ADA and the Olmstead decision, and additional training in how to implement those responsibilities.
6. The PSTs need to receive substantially more training in how to use the PFA as a tool to guide a conversation, rather than as a rote completion of a checklist of questions.

The following are offered as additional suggestions to the facility:

1. In implementing the new policy, consider some type of peer review process to facilitate good learning across teams.
2. Consider developing criteria and methods by which to include necessary professional clinicians in PSP meetings where such attendance is important to future planning for the individual.

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. Denton State Supported Living Center (DSSLC) Plan of Improvement (POI), updated 03/15/2011 2. DSSLC's Report for Monitors, dated March 28, 2011 3. DADS Draft Policy 005 Minimum & Integrated Clinical Services dated 01/12/2010 4. Medical records including consultation reports for Individuals #226, #242, #295, and #772 5. PSPs and other documents reviewed by all members of the Monitoring Team **People Interviewed:** 1. Interviews with various discipline staff by the members of the monitoring team, as identified in other sections of this report. **Meetings Attended/Observations:** 1. PSP annual planning meeting for Individual #772
	Facility Self-Assessment: The Facility reported that it was not in compliance with either provision of this Section. Medical rounds had been expanded to include additional disciplines. The Facility also reported that decisions to agree to or choose not to adopt recommendations from consultations are documented in the integrated progress notes. The Monitoring Team found additional actions taken by the Facility that promote integrated planning. Nevertheless, the Monitoring Team concurs with the Facility's report on both provisions.
	Summary of Monitor's Assessment: The Facility had taken several actions that involved interdisciplinary involvement, such as converting to the new PSP process, involving psychiatrists in the PSP and ensuring their involvement with consultant neurologists and with the pharmacist in the QDRR process, initiating collaborative work on diabetes and skin integrity, and involving a speech and language pathologist in the PBSP process. Although there has been improvement in participation by more disciplines in the PSP process, there is still a lack of participation by some disciplines, such as Speech and Language Pathology Nevertheless, much involvement in PSP planning remains multidisciplinary. The involvement of clinicians in collaborative activities and PSP planning is an initial step in developing integrated discussion and decision-making, and further improvement must continue to occur. Facility clinicians documented that they reviewed recommendations from non-Facility clinicians. They did not always document whether they accepted or rejected recommendations or whether recommendations were referred to the PST.

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#	Provision	Assessment of Status	Compliance
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.	An overall facility plan was not in place to address this item, although a number of activities were occurring (see below). A facility policy did not exist; however, a draft DADS statewide policy was available. This state policy was not yet complete. It addressed both integrated clinical services (section G) and minimum common elements of clinical services (section H). The aspects of the policy that addressed section G were minimal and will not likely be helpful to the facility because the policy merely mimicked the wording of the Settlement Agreement without providing any direction to the facility, such as specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring. Staff were trained in the new PSP process, which promotes interdisciplinary discussion during planning meetings. However, although progress had been made in development of interdisciplinary participation in a number of areas and the PSP planning meeting no longer involved reading of reports and recommendations, the process remained multidisciplinary in the sense that much decision-making still was done by disciplines rather than through thorough PST discussion. Furthermore, there is still a lack of participation by some disciplines. For example, Speech and Language Pathologists (SLPs) still did not participate in the PSPs for individuals with severe or moderate speech deficits outside of Cedar Falls. This is a direct result of not having enough therapists. One area of improvement was participation by psychiatrists in the PST. At the time of the tour, 258 individuals who lived at DSSLC received some form of psychiatrist support. The job descriptions of the psychiatrists included responsibilities for direct psychiatric care of designated individuals; Psychiatrists were members of the Personal Support Teams (PSTs) of individuals assigned to their care. They participated in PST activities, including annual PSP meetings. Individuals were seen for psychiatric care as needs arose, and at regularly scheduled Psychiatry Medication Reviews (PMRs), which occurred on a monthly to quarterly basis. PMR participants included the individual being reviewed, and the individual's psychologist, qualified mental retardation professionals (QMRP), nurse case manager, direct support professionals and other members of the PST. Quarterly psychiatric meetings also served as the place where quarterly reviews of the PSP took place. Psychiatrists worked closely with other professionals at the Facility. They worked with pharmacy department members, and they reviewed Quarterly Drug Regimen Reviews (QDRRs) that were prepared by pharmacists; they worked closely with nurse case managers and they reviewed the DISCUS and MOSES screenings that had been completed by those nurses. Along with other physicians, the psychiatrists participated in medical	Noncompliance

#	Provision	Assessment of Status	Compliance
		department activities, they attended monthly polypharmacy meetings, and they participated on a rotating basis as members of the Pharmacy and Therapeutics Committee (P&TC). On the basis of records reviews, interviews, and observations made during meetings, the Monitoring Team found that there was good collaboration regarding pharmacological treatments at DSSLC across disciplines, and that behavioral data was considered in decisions. However, the Monitoring Team found that the overall process remained multidisciplinary rather than interdisciplinary. That is, the Monitoring Team found deficiencies in the process that brought together information from different disciplines in the way that joint/interdisciplinary clinical determinations were made, and in the way that the resulting information was recorded and carried forward over time. The combined formulations provided integrated information from the various disciplines variably. The Monitoring Team found that in some cases the formulations were integrated and interdisciplinary. In other cases, the formulations were parallel and multidisciplinary. On the basis of examination of the records, discussion with the psychiatrists, and observations made at the time of the clinic the Monitoring Team found that coordination between psychiatry and neurology and psychiatry remained strong and supports the Facility's continued attention to behavioral side effects – both positive and negative - of medications prescribed for epilepsy. Other areas of improvement included the following: • The Skin Integrity Nurse involved numerous other disciplines to improve treatment and prevention of pressure ulcers; she notified these staff by email following assessment of individuals. It was evident that the other disciplines responded promptly. • The Diabetic Educator Nurse had worked collaboratively with the Dietitian and Endocrinologist and physician to manage Individual #367's diabetic condition by closely monitoring blood sugar level, dietary intake and adjustment to insulin regimen. • The SLP had begun to attend all Positive Behavior Support Committee meetings and provide consultation to the applicable psychologists regarding speech or language issues that may be contributing to the target behavior.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two	The Monitoring Team reviewed consultations and medical records for four individuals (totaling six consultation reports). There was documentation that appropriate Facility clinicians reviewed recommendations from non-Facility clinicians but little	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	documentation that recommendations were approved, rejected, or referred to the PST for integration with existing supports and services. For all six consultations, review by the Facility clinician was documented. For three of six consultations (50%), there was documentation that the recommendation was accepted; for the other three (50%), there was no documentation of acceptance, rejection, or referral to the PST.	

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

1. The Facility should establish in the PSP mentoring process measures of integrated planning and use those to provide feedback and coaching.

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. Denton State Supported Living Center (DSSLC) Plan of Improvement (POI), updated 03/15/2011 2. DSSLC's Report for Monitors, dated March 28, 2011 3. DADS Draft Policy 005 Minimum & Integrated Clinical Services dated 01/12/2010 4. PSPs, CLDPs, and other documents reviewed by members of the monitoring team, as identified in other sections of this report. 5. Records reviewed as identified in Sections J, K, L, M, O, P, Q, and R **People Interviewed:** 6. Interviews with various discipline staff by the members of the monitoring team, as identified in other sections of this report. **Meetings Attended/Observations:** PSP annual planning meeting for Individual #772
	Facility Self-Assessment: The Facility reported that it was not yet in compliance with any provision of this Section except Provision H.2. For Provision H.1, the Facility reported that it had implemented a new physician transfer form for hospital discharges. The annual physical assessment form was revised to include all components of the Health Care Guidelines (HCGs). For Provision H.2, the Monitoring Team found descriptions of psychiatric conditions that did not correspond to the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems. Therefore, the Monitoring Team does not concur with the Facility's finding of compliance. For Provision H.7, the Facility reported it had implemented the At-Risk Policy, the PSP policy, and the Incident Management policy. The Monitoring Team agreed that these had been implemented but also agreed with the Facility that this provision was not yet in compliance, in part because (as reported in other Sections of the SA), implementation of these policies was not yet complete and effective. The rest of the actions involved reminders to clinicians to address timely and clinically appropriate treatments and interventions, tracking and trending some data on medication use, and developing a list of individuals at high risk in a few categories. Although these were positive steps, they did not yet meet the requirements in the provisions of this Section.
	Summary of Monitor's Assessment: Progress had been made in completing assessments but not yet to the point of compliance with any

	provisions of this Section. The Facility had started to do annual psychiatric assessments but not in performing intellectual and adaptive assessments. Collaborative reviews by both psychiatry and psychology took place at psychiatric treatment reviews. Integrated data in the PBSP was, however, lacking, so monitoring was not tied to objective information on clinical indicators. Interventions were not always implemented timely; in some cases, there was not timely assessment conducted to guide development of intervention. The Active Problem List used descriptions of psychiatric conditions that did not correspond to the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems. The Monitoring Team determined that the Facility did not yet comply with any provision of this section.

#	Provision	Assessment of Status	Compliance
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.	There were improvements in performance of assessments and evaluations in some areas but not across all disciplines. The Facility had started to do annual psychiatric assessments in addition to the monthly and quarterly PTRs. Annual and quarterly nursing assessments were completed according to schedule. The new physician transfer order form was implemented to ensure continuity of care when an individual is discharged to the Facility from the hospital. Little progress was achieved by DSSLC in integrating adaptive and intellectual testing into the psychological assessment process. Few psychological assessments included an intellectual assessment administered within the previous five years or an adaptive assessment conducted within the prior year. As described in Provision P.1, the PNM Team met regularly but did not meet timely to address change in status, assessment, clinical data and monitoring results.	Noncompliance
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	The Active Problem List used descriptions of psychiatric conditions that did not correspond to the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems. For individual # 127, the entry for the problem list was "mental disorder – history of aggression," and for individual #319 the entry was "behavior disorder." These entries did not correspond to current or prior psychiatric diagnoses and they were not Diagnostic	Noncompliance

#	Provision	Assessment of Status	Compliance
	with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems (DSM/ICD) diagnoses. Therefore, the Monitoring Team did not concur with the Facility's self-assessment of compliance and determined that the Facility did not comply with this provision.	
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.	Interventions were not always implemented timely; in some cases, there was not timely assessment conducted to guide development of intervention. • Based on a review of 19 individual records, documentation supported that the PNM Team met regularly but did not meet timely to address change in status, assessment, clinical data and monitoring results. • For Individual #367, target behaviors began increasing in June 2010 and, with the exception of August, remained substantially elevated through the end of 2010. Despite data that indicated worsening undesired behavior, progress notes provided no information about any specific anticipated benefit from continuing the existing PBSP. Furthermore, no recommendations were made to revise the PBSP or explore the lack of treatment efficacy. In January of 2011, however, when displays of target behaviors dropped to near zero, the recommendation was made to revise the PBSP. Although data suggested the PBSP was ineffective, a revision to the PBSP would have provided greater potential benefit had revisions been introduced in a more timely manner. • Recommendations for AAC and EC equipment were not implemented in a timely manner. For example: o Individuals #645, #691, #571's devices were ordered in February, 2010 but the devices still have not arrived. o Individuals #114, #171, and #696 did not have Training Documentation Reports (TDRs) implemented as stated by the assessment. it was not evident that evidence-based decisions regarding treatment were routinely formed or even possible due to lack of appropriate data and assessments.	Noncompliance
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	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. The Facility did not have a medical quality improvement process that included review of clinical indicator. The Facility should develop a system that will capture medical indicators, such as specific conditions, hospitalizations, EMS calls, deaths, and importantly, data points, such as laboratory and other diagnostic results, that can demonstrate efficacy of clinical practice at the Facility. Data must be maintained longitudinally and must be used to conduct trend analysis regularly, identify areas for	Noncompliance

#	Provision	Assessment of Status	Compliance
		attention and improvement, and determine effectiveness of initiatives taken to improve health status and services. Data specific to clinical outcomes were not collected, nor was trend analysis completed. Outcome data, such as diagnostic results that indicated appropriate clinic treatment (e.g., improved or normal A1C levels in people with diabetes, improved bone density measurements following treatment for low bone density), as well as other variables, 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. The Aspiration Trigger data Sheet was in the process of being implemented for the individuals who were on the target list. The trigger data sheet was designed to monitor the presence or absence of triggers related to potential aspiration. The development of this data sheet is another positive step forward in better being able to identify signs and symptoms. The issue with the existing Data sheet included: • Lack of individualized triggers • Lack of notification of all occurring triggers. For example, a trigger may not be documented or nurse notified if the trigger stopped occurring after repositioning or plan implementation. As described in Provision J.9, for many individuals, symptom monitoring for mental health condition, needed for assessment of treatment efficacy, was not in place.	
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.	Based on the review of 19 individual records, the PNM Team or PST 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. A policy/protocol that addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted does not exist at DSSLC. Lacking is: 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	Noncompliance

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		clinician. Collaborative reviews by both psychiatry and psychology took place at psychiatric treatment reviews. Integrated data in the PBSP was, however, lacking, so monitoring was not tied to objective information on clinical indicators.	
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.	Numerous examples were found in which treatments and interventions were not modified in response to clinical indicators. • For Individual #367, target behaviors began increasing in June 2010 and, with the exception of August, remained substantially elevated through the end of 2010. Despite data that indicated worsening undesired behavior, progress notes provided no information about any specific anticipated benefit from continuing the existing PBSP. Furthermore, no recommendations were made to revise the PBSP or explore the lack of treatment efficacy. In January of 2011, however, when displays of target behaviors dropped to near zero, the recommendation was made to revise the PBSP. Although data suggested the PBSP was ineffective, a revision to the PBSP would have provided greater potential benefit had revisions been introduced in a more timely manner. • For Individual #127, overall displays of aggression increased beginning in June, 2010 and remained elevated into November 2010. The overall frequency of aggression increased again in January, 2011 by more than 500% over previous maximum levels. Despite elevated levels of aggression, the PST did not recommend a revision to the PBSP until the annual PSP on 3/3/2011. • As described in Provision P.1, the PNM Team met regularly but did not meet timely to address change in status, assessment, clinical data and monitoring results. For example: o Individual #245 developed aspiration pneumonia on 10/26/10 but there was no evidence that the PNMT or PST met to discuss to discuss the aspiration post hospitalization. o Individual #537 had a choking event occur on 1/14/2011 post visit to have teeth extracted. There was no evidence of discussion prior to return to home regarding whether diet texture should be temporarily modified. There were also examples of treatment provided when indicated. For example, as described in Provision M.1, successful treatment of skin breakdown was initiated, and objective measures of healing were tracked.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with	A draft DADS state policy was available and this was an improvement since the last onsite review. It addressed provisions G and H together. The policy was not yet	Noncompliance

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	full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	completed or disseminated. The majority of the policy addressed section H and appeared to be a good start to providing the facility with some guidance and direction. It might be helpful to indicate how the contents of the policy related to each of the specific seven provision items of provision H. For provision item H1, the policy listed some details about the regulatory or statutory requirements for a nursing quarterly review, an annual dental exam, a review of behavior control drugs, an annual physical, and a review of risk status. There was nothing in the policy, however, regarding assessments and evaluations for psychiatry, psychology, pharmacy, physical therapy, speech and language therapy, dietary needs, occupational therapy, and respiratory therapy (in this policy, DADS added respiratory to the list of clinical services). There were improvements in performance of assessments and evaluations in some areas but not across all disciplines. The Facility had started to do annual psychiatric assessments in addition to the monthly and quarterly PTRs. Annual and quarterly nursing assessments were completed according to schedule. The new physician transfer order form was implemented to ensure continuity of care when an individual is discharged to the Facility from the hospital. Little progress was achieved by DSSLC in integrating adaptive and intellectual testing into the psychological assessment process. Few psychological assessments included an intellectual assessment administered within the previous five years or an adaptive assessment conducted within the prior year. As described in Provision P.1, the PNM Team met regularly but did not meet timely to address change in status, assessment, clinical data and monitoring results.	

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

1. The Facility should ensure that assessments and evaluations are done routinely as required.
2. The Facility should develop a system to monitor whether changes in health and behavioral status of individuals trigger assessments as required.
3. The Facility should develop a system that will capture medical indicators, such as specific conditions, hospitalizations, EMS calls, deaths, and importantly, data points, such as laboratory and other diagnostic results, that can demonstrate efficacy of clinical practice at the Facility.

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. DADS Policy Draft (undated) 006 – Risk Management. 4. DSSLC Policy CMGMT -14 At Risk Individuals 1/1/11 5. List of Health Risk Ratings for each risk factor/individual 3/30/11. 6. Records reviews for Individuals #131, #181, #201, #218, #245, #272, #336, #401, #419, #519, #537, #548, #578, #580, #699, #758, #761, #776, and #781 7. Integrated risk reviews for Individuals #131, #181, #201, #218, #245, #272, #336, #401, #419, #519, #537, #548, #578, #580, #699, #758, #761, #776, and #781 8. Risk Action Plan for Individuals #338, #205, #681, #108, #401, #519, #164, #188, #276, and #19 9. List of Top 10 aggressive individuals causing injury to peers. 10. List of Top 10 injured individuals. 11. List of individuals supported with bedrails 12. List of individuals injured from bedrails **People Interviewed:** 13. Nancy Condon, DSSLC Facility Director 14. Dora Tillis, Assistant Director of Programs 15. Donna Groves, OTR, Director of Habilitation Services 16. Joy Sibley SLP, Director of Communication Therapy 17. Lori Powell, Director of Quality Assurance 18. Deb Salsman, Director of Incident Management 19. Randy Spence, M.S., Director of Behavioral Services 20. Elaine Davis, Director of Training and Development 21. Six DCPs Cedar Falls 22. Three DCPs Houston Park **Meetings Attended/Observations:** 1. IMT meeting 3/28/11 2. Observations of mealtimes on Cedar Falls 3. Life skills-Cedar Falls 4. PNMT meeting 3/28/11 5. Incident Management Team (IMRT) 3/28/11 6. Restraint Reduction Committee 3/30/11 7. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 3/31/11
	Facility Self-Assessment: In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance any of the provisions of this section of the Settlement Agreement. The Monitoring Team concurs.

	The state established a new at risk policy dated 12/29/10 to be effective 1/1/11. DSSLC reported it began implementing the new policy on 1/31/11. The monitoring team had an opportunity to review risk rating assessments completed under the new policy and believes the new process is much more likely than the old process to accurately reflect risk levels for individuals living at the DSSLC.
	Summary of Monitor's Assessment: The state established a new at risk policy dated 12/29/10 to be effective 1/1/11. DSSLC reported it began implementing the new policy on 1/31/11. The monitoring team had an opportunity to review risk rating assessments completed under the new policy and believes the new process is much more likely than the old process to accurately reflect risk levels for individuals living at the DSSLC. The risk assessment system used prior to implementation of the new policy continued to inaccurately assess risk levels for individuals. This was the operative policy for some of the time period for this compliance review, A concern with the new procedure is that the risk guidelines provided to QMRPs were based primarily on the history of the indicator occurring and not on indicators that lead to an increased risk. Guidelines need to be expanded to promote proactive review of risk. The Monitoring Team is concerned with bedrail safety at DSSLC. DSSLC reported 115 individuals use bedrails and five individuals had bedrail related injuries between 10/1/10 and 3/12/11. In response to a document request for "any facility policy governing bedrail use or safety review" the facility responded it had no local policy. In response to a document request for "a copy of bedrail safety assessments, either a comprehensive report or assessments done of specific individuals and their use of bedrails" the facility responded they had none. Bedrails, which are often used out of concern for safety, can instead increase risk of injury if care is not taken. The Monitoring Team was informed after the visit that the Facility had checked the bedrails against the FDA Entrapment Codes 2-5 years ago and has, since the visit, established a committee to review beds, mattresses, and bedrails. Periodic re-evaluation is important and the establishment of that committee is a good idea.

#	Provision	Assessment of Status	Compliance
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.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. The state established a new at risk policy dated 12/29/10 to be effective 1/1/11. DSSLC reported it began implementing the new policy on 1/31/11. The Monitoring Team had an opportunity to review risk rating assessments completed under the new policy and believes the new process is much more likely than the old process to accurately reflect risk levels for individuals living at the DSSLC. The risk assessment system used prior to implementation of the new policy continued to inaccurately assess risk levels for	Noncompliance

#	Provision	Assessment of Status	Compliance
		individuals. This was the operative policy for some of the time period for this compliance review, the Monitoring Team could not yet assess whether the new rating system would be implemented routinely and accurately to identify individuals whose health or well-being is a risk. The Monitoring Team was concerned about a risk that was observed. The Facility used flat bath slabs for some individuals at Cedar Falls unit. These flat slabs place individuals in a position that could cause risk for aspiration. The Facility should consider replacing the slab baths with adjustable height bathing systems with built-in/adjunct lifts for safety. The Facility should assure that individuals with hypothermia and those with significant risks related to osteoporosis are provided with alternatives to a slab bath and contraindications are noted in their HMPs, and that individuals who have aspiration risks have been assessed for appropriate elevation and the proper bolsters and wedges provided (noting that wedges were provided at DSSLC).	
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.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. DSSLC Policy CMGMT -14 At Risk Individuals 1/1/11 is intended to guide facility practice directed at this provision of the SA. Based on a review of 19 individual records, documentation supported that the PNM 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 Team or PST did not meet regularly to address change in status included: • Individual #245 developed aspiration pneumonia on 10/26/10 but there was no evidence that the PNMT or PST met to discuss to discuss the aspiration post hospitalization. • Individuals #131 and #548 had a modified barium swallow study conducted on 12/21/2010. There was no evidence that the PST or PNMT met to discuss the findings of the test and determine if there was a need to revise the current plan of care • Individual #537 had a choking event occur on 1/14/2011 post visit to have teeth extracted. There was no evidence of discussion prior to return to home regarding whether diet texture should be temporarily modified. Additionally, there was no evidence that the PST met to discuss findings of a meal observation that occurred on 1/14/11 • Individual # 761 had a choking event on 11/15/10 but there was no evidence of PNMT or PST discussion or evaluation of the event outside of the	Noncompliance

#	Provision	Assessment of Status	Compliance
		incident report. • Individual # 419 developed aspiration pneumonia on 11/5/10. The team met to discuss the hospitalization but there was no evidence that the PNMT or PST met to discuss the findings of the MBSS that was conducted on 11/18/10 • Individual #699 developed aspiration pneumonia on 12/10/2010 but there was no evidence that the PNMT or PST met to discuss issues until the PSP meeting on 1/14/11. The PST did not meet post hospitalization to discuss the aspiration event.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. DSSLC Policy CMGMT -14 At Risk Individuals 1/1/11 is intended to guide facility practice directed at this provision of the SA. As of 12/20/10 the DSSLC has been using a standard format for risk mitigation planning. A form "Risk Action Plan" identifies action steps, implementation date, monitoring frequency, person responsible, completion date, and follow-up/outcome. These plans tended to be too general and seemed to serve the function of summarizing information rather than providing specific instructions. For example, several Risk Action Plans described monitoring frequency as "daily" or "as needed" without specifying time of day such as a specific meal or mealtime. Similarly, completion dates were typically noted as "ongoing" or contained a date one year forward suggesting the action plan and monitoring was unlikely to have a positive effect.	Noncompliance

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

1. Ensure that appropriate assessment and revision of the PSP is done for any individual whose level of risk is revised as the At-Risk Individuals policy is implemented.
2. Fully implement DADS Policy 006 – At Risk Individuals.
3. As the new At-Risk process evolves, assessment guidelines should promote proactive review of risk as well as addressing risk indicator events that have already occurred.
4. Ensure that appropriate assessment and revision of the PSP is done for any individual whose level of risk is revised as the At-Risk Individuals policy is implemented.
5. Replace flat bath slabs with tubs adapted to meet the needs of thjs population.

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. Denton State Supported Living Center (DSSLC) Plan of Improvement (POI), 03/25/2011 2. Texas Department of Aging and Disability Services (DADS) Policy 001: Use of Restraints (08/15/09) 3. DSSLC Policy and Procedure CMGMT-21: Dental/Medical Sedation and Restraint (11/05/09) 4. DADS Policy 008.01: Psychological and Behavioral Services (07/22/10) 5. DSSLC Policy CMGMT-24: Psychological Services (11/30/10) 6. Monitoring Team pre-tour document request: Section VII – Psychiatry 7. For Individuals #4, #12, #14, # 89#119, #127, # 138, #153, # 231, #232, #278, # 319, #335, #341, #353, #372, #402, #417, #423, #464, #472, #494, #505, #537, #539, #583, #593, #605, #612, #637, #653, #669, #689, #690, #734, 765, and #772: Psychiatric evaluations in the Settlement Agreement (SA) Appendix B format 8. For Individuals #12, #110, #127, #153, #278, #285, #395, #417, #423, #472, #494, #583, #605, and #62: Demographic Information (e.g., Profile Sheet – Photograph and Identifying Information Sheet), Social History Evaluation, most recent Personal Support Plan (PSP), most recent Positive Behavior Support Plan (PBSP), Annual Medical Summary, Active Problem List (APL), most recent Health Risk Assessment Rating – tool and team meeting sheet, Psychiatry section inclusive of the most recent Comprehensive Psychiatric Assessment, most recent MOSES/DISCUS Side Effects Screening, most recent Quarterly Drug Regimen Reviews (QDRR), most recent Neurology Consultation; any documentation and consultations regarding the use of pretreatment sedation medication (i.e. Treatment Plan, Guardian Approval, Human Rights Committee (HRC) approval, etc.), Informed Consent forms for all current psychotropic medications 9. For Individuals #12, #110, #153, #285, #278, #395, #417, #423, #494, #583: Medication Plans (new format), Consent for Psychotropic Medication (new format), recent Psychiatry Medication Review (PMR) notes. 10. For Individuals #183, #228, #269, #278, #312, #367, #414, #472, #540, #583, #590, #664, #723,and #782, all for specified dates: All documentation associated with medical restraints, including restraint checklist/face-to-face assessment & debriefing documents, medical orders, physician specified monitoring schedule, any standard facility protocol for monitoring medical restraint, any PSP information regarding development and/or implementation of plans to minimize use of medical restraint for the individual (including data sheets if a program was developed and implemented), documentation of review activity, and any other documentation associated with the restraint use 11. For Individuals #217, #244, #270, #429, all documentation associated with intravenous dental sedation on specified dates, including restraint checklist/face-to-face assessment & debriefing documents, medical orders, physician specified monitoring schedule, any standard facility protocol for monitoring medical restraint, any PSP information regarding development and/or implementation of plans to minimize use of medical restraint for the individual (including data sheets if a program was developed and implemented), documentation of review activity, and any other information associated

	with the restraint use. 12. For Individuals #127 and #624: PSP Plans of Action and any related documents related to multiple restraints to the individuals, between September 2010 and February 2011 13. For Individuals #4, #12, #22, #26, #34, #92, #170, #178, #240, #245, #337, #354, #357, #364, #381, #382, #438, #488, #517, #527, #573, #589, #611, #621, #628, #717, #755, #758, #766, and #775: Reiss Screen booklets and scoring sheets. 14. For Individuals # 56, #101, #130, #170, #189, and #510: Reiss Screen booklets and scoring sheets, and any resulting psychological assessments or other clinical evaluations. 15. For Individuals #89, #402, #417, #423, #464, #583, and #772: Psychiatric consultation materials, Reiss Screens booklets and scoring sheets. **People Interviewed:** 1. Robert Harden, M.D., DSSLC Consulting Psychiatrist 2. Zourong Lin, M.D. , DSSLC Staff Psychiatrist 3. Arifa Salam, M.D., DSSLC Lead Psychiatrist 4. Satyajit Satpathy, M.D., DSSLC Staff Psychiatrist 5. Sibylle Graviett, RN, RN Case Manager Supervisor 6. Delia Schilder, RN, CDDN, CNE 7. Randi Spence, MA Director of Psychology 8. Frank Pedia, Director of Program Coordination 9. Jill Wooten, BCBA, Positive Behavior Support Committee (PBSC) Chair **Meetings Attended/Observations:** 1. PSP planning meeting for Individual #395 (04/01/2010) 2. Psychology/Neurology conference (03/31/2010) 3. Quality Assurance/ Quality Improvement Council (04/01/2010) 4. Psychiatry Clinic – Dr. Salam (04/01/11) 5. PBSC meeting (03/31/11)
	Facility Self-Assessment: The Facility reported that it complied with seven of the fifteen provisions of the psychiatry section of the SA. The Facility self assessed compliance with professional staffing requirements. The POI reported that deployment of the Reiss Screen for Maladaptive Behavior was complete, and that identified individuals were referred to the psychiatry clinic for evaluation/assessment. A system was reported to be in place for monitoring, detecting, and reporting side effects of medications, and for facility level reviews of polypharmacy practices. The Facility also self-assessed that psychiatrists coordinated the use of medications prescribed to treat both seizures and mental health disorders with the consulting neurologist. The Monitoring Team concurred with these elements of the self assessment. The Facility also self-assessed compliance with requirements for the monitoring and coordination of pre-treatment sedation with psychiatric, pharmacy, and medical services, and reported progress in the development of desensitization and other treatments to minimize the need for such sedation. However, the Monitoring Team found that adequate procedures were not in place to fulfill the SA requirement for monitoring during pre-treatment sedation, and that the process of the development of needed treatments was in its early stages.

	The Facility did not self-assess compliance on SA provisions that related to psychiatric evaluations, but reported that psychiatrists had started to use the required formats for psychiatric evaluations, at the time of admission to the facility and during annual clinical updates. The Monitoring Team concurred that good progress was made in the area of psychiatric assessments. The Facility self- reported improvements in the integration of pharmacological treatments with behavioral interventions, and improvements in the integration of psychiatry and psychology via use of combined case assessments and formulations. In these areas the Monitoring Team found that the needed improvements were in their early stages. The Facility reported that a new system was in place to implement and monitor medication treatment plans. The Monitoring Team concurred that progress was made in these areas also, and concurred that the Facility was not yet in compliance.
	Summary of Monitor's Assessment: **For provision J1:** The provision remained in substantial compliance: The Facility continued to employ three full time staff psychiatrists and one part time contract psychiatrist, all of whom were board certified in psychiatry and all of whom had sufficient experience with intellectual disabilities. The psychiatrists actively and appropriately participated in the interdisciplinary process. **For provision J2**: The provision was determined to be in substantial compliance. A process was in place for individuals to receive clinically justifiable evaluations and diagnoses by board certified or board eligible psychiatrists. **For provision J3:** The provision was determined to be not in compliance. There was much improvement in the area of the appropriate use of psychotropic medications. However, there needed to be greater clarity about the rationale for the use of each medication, and further progress needed to be made to assure that all psychotropic medications were properly linked to symptoms or behavioral characteristics of identified psychiatric disorders. **For provision J4:** The provision was determined to be not in compliance. The Facility had established a credible process for the development of desensitization plans for identified individuals, but that process had just started. While procedures for medical restraint monitoring in the dental clinic were in place, appropriate procedures had not been established regarding the use of pretreatment sedation for medical procedures. **For provision J5:** The provision remained in substantial compliance. Psychiatrists at the Facility had heavy clinical caseloads and were very busy, but with the support of the psychiatric assistants and others, they were able to provide the services required by the SA. **For provision J6:** The provision was determined to be not in compliance. The Facility had successfully deployed the use of Appendix B evaluations for new admissions, annual reviews, and consultations. With the above in mind, the Facility's decision to deploy the Appendix B format for over 250 individuals during a single annual cycle was both ambitious and commendable. However, additional details were sometimes needed regarding the reasons that diagnoses were selected, and in some cases a more detailed review was

	needed in descriptions of the course of illness, past treatment trials, and the results of those trials. **For provision J7:** The provision was determined to be in substantial compliance. Reiss screens were administered to all individuals who required them. Psychiatric assessments were completed for all individuals who had psychiatric diagnoses, or who received psychotropic medication. **For provision J8:** The provision was determined to be not in compliance. The Monitoring Team confirmed that behavioral data were considered in decisions regarding pharmacological treatments. However, a process was not in place to provide integrated behavioral care through combined assessment and case formulation. **For provision J9:** The provision was determined to be not in compliance. The way in which the Personal Support Teams (PSTs) determined which treatments were likely to be most helpful to individuals was not clear, and PBSPs did not adequately describe the treatments that were selected. **For provision J10:** The provision was determined to be in substantial compliance. New procedures were in place to assure that prior to the administration of psychotropic medications, the PST (including the psychiatrist, Primary Care Physician [PCP] and nurse) considered both the risks of the untreated mental illness and the risks associated with the proposed treatment. To remain in compliance, the Facility must provide clarification/assurances about the procedures, and provide details about the way reasonable alternatives to treatment were considered. **For provision J11:** The provision was determined to be in substantial compliance. The Facility had established a psychoactive medication oversight committee, and that committee had started to meet. The committee will monitor the reduction and elimination of psychotropics that were not clinically justified. **For provision J12:** The provision was determined to be in substantial compliance. The Facility had established a process for facility-wide monitoring of side effects, in conjunction with the psychoactive medication oversight committee. **For provision J13:** The provision was determined to be not in compliance. The Facility had started a new system for psychotropic medication treatment plans. However, the plans reviewed lacked clear rationales for the proposed treatments, and the system under which individuals were monitored for treatment efficacy needed to be improved. **For provision J14:** The provision was determined to be not in compliance. The Facility started a new process for psychotropic medications consent. Clarification was needed about consent procedures for other restrictive procedures, **For provision J15:** The provision was determined to be in substantial compliance. Staff psychiatrists attended neurology clinics, and a process for review and oversight of medications prescribed by both neurology and psychiatry were in place.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	At the time of the compliance visit DSLLC continued to employ three full time staff psychiatrists: Drs. Lin, Satpathy and Salam. A fourth psychiatrist, Dr Harden was employed as a contractor for eight hours per week. All four psychiatrists were interviewed during the tour, and their curriculum vitae, medical licenses, and specialty board certificates were reviewed. Drs. Harden, Salam and Satpathy were board certified by the American Board of Psychiatry and Neurology, and Dr. Lin was board eligible. Since the time of the last tour Dr. Harden's assignments had changed. At the time of the tour he divided his time between quality assurance reviews and activities as a member of the PBSC. Dr Salam served as lead psychiatrist for the facility and participated in facility-wide oversight activities. In addition, Dr. Salam served as the lead psychiatrist for the Facility. Drs. Lin, Salam, and Satpathy all maintained active caseloads. At the time of the tour, 258 individuals who lived at DSSLC received some form of psychiatrist support. The job descriptions of the psychiatrists included responsibilities for direct psychiatric care of designated individuals; Psychiatrists were members of the Personal Support Teams (PSTs) of individuals assigned to their care. They participated in PST activities, including annual PSP meetings. Individuals were seen for psychiatric care as needs arose, and at regularly scheduled PMRs, which occurred on a monthly to quarterly basis. PMR participants included the individual being reviewed, and the individual's psychologist, qualified mental retardation professionals (QMRP), nurse case manager, direct support professionals and other members of the PST. Quarterly psychiatric meetings also served as the place where quarterly reviews of the PSP took place. Psychiatrists worked closely with other professionals at the Facility. They worked with pharmacy department members, and they reviewed Quarterly Drug Regimen Reviews (QDRRs) that were prepared by pharmacists; they worked closely with nurse case managers and they reviewed the DISCUS and MOSES screenings that had been completed by those nurses. Along with other physicians, the psychiatrists participated in medical department activities, they attended monthly polypharmacy meetings, and they participated on a rotating basis as members of the Pharmacy and Therapeutics Committee (P&TC). During the tour the Monitoring Team observed the work of the psychiatrists, during PMRs, during an annual PSP meeting, during a psychiatry/neurology conference and during the psychiatrist's work with the PBSC and Quality Assurance (QA) and Quality Improvement (QI) Committee. Overall, the Monitoring Team found that the psychiatric staff at DSSLC consisted of qualified professionals, who participated meaningfully in the DSSLC interdisciplinary process.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	The Monitoring Team reviewed psychiatric evaluations for Individuals #4, #12, #14, # 89 #119, #127, # 138, #153, # 231, #232, #278, # 319, #335, #341, #353, #372, #402, #417, #423, #464, #472, #494, #505, #537, #539, #583, #593, #605, #612, #637, #653, #669, #689, #690, #734, 765, and #772. The Monitoring Team addressed the following items: 1. Whether the Facility employed a sufficient number of psychiatric hours to ensure that evaluation and diagnosis can be done in a clinically justifiable manner: Since the last compliance tour the Facility had maintained a staffing level of 3.2 Full Time Equivalent (FTE) psychiatrists, one of whom is now deployed to quality assurance and committee oversight duties. Since at the time of tour there were 258 individuals who received psychiatric care; the average caseload for the psychiatrist was between 85 to 90 individuals. This represented a busy, but manageable caseload for the psychiatrists. 2. Whether a mechanism was in place for all psychotropic medication to be used based on clinically justifiable evaluation and diagnoses: Diagnostic evaluation were (evaluation per Appendix B of the SA) the subject of Provision J6. Generally, a positive process was determined to be in place. 3. Whether a mechanism was in place for all psychotropic medications to be used on the basis of clinically justifiable evaluation and diagnoses: In the report for the last compliance visit the Monitoring Team focused on the need to link in a meaningful and transparent way the use of the medication to symptoms or behavioral characteristics of the identified psychiatric disorder. The Facility responded to this by introducing a medication plan process initiated by the psychiatrist when a new medication is proposed. The medication plan process was reviewed by the Monitoring Team under provision J13. It was found to be generally positive, although a clear statement about the reason for the medication's use (treatment rationale) should he added. 4. Evaluation and diagnosis conducted by qualified psychiatrists: All evaluations were completed by DSSLC board certified psychiatrists. 5. In the report for the last compliance visit, the Monitoring Team identified the need to identify a process of review and improvement, to ensure that evaluations and diagnoses were done in a clinically justifiable manner. In the May 2010 POI the Facility stated that it did not have enough data to support compliance at that time. There has been no update to that statement.	Substantial Compliance
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	The Monitoring Team reviewed information on Individuals #12, #110, #127, #153, #278, #285, #395, #417, #423, #472, #494, #583, #605, and #62. Materials reviewed included demographic information (e.g., profile sheet – photograph and identifying information Sheet), most recent PBSP, annual medical summary, the APL, the most recent health risk assessment rating – tool and team meeting sheet, the psychiatry	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	section inclusive of the most recent psychiatric assessment, most recent MOSES/DISCUS side effects screening, recent QDRRs, the most recent neurology consultation, medication plans, informed consent forms. The Monitoring Team evaluated whether the use of psychotropic medications at the Facility was appropriate, on the basis of the seven items listed for this provision in the rating tool agreed upon by the parties. The Monitoring Team found that psychotropic medications were used at DSSLC as part of treatment programs, psychotropic medications were not used as punishments, and that psychotropic medications were not used for the convenience of staff. There were no examples of psychotropic medications being used in the absence of a documented psychiatric or neuropsychiatric diagnosis or specific behavioral pharmacological hypothesis. However, for many medications a clear rationale for the use of the medication was not provided, and medications were not linked to symptoms or behavioral characteristics of psychiatric disorders. Examples are provided in the Monitoring Team's comments for provision J9, item #2. The Facility included APLs as part of the health data tab of the record, and they were also part of the annual physicians' summary. The fourteen records listed above were examined, to see if the psychiatric diagnoses were included on the APLs. In six of the fourteen records reviewed, the problem list did not include the current psychiatric diagnosis. In two cases (Individuals # 423 and #605), the reason could have been that the psychiatric diagnosis changed after the annual medical review was completed. For individual # 127, the entry for the problem list was "mental disorder – history of aggression," and for individual #319 the entry was "behavior disorder." These entries did not correspond to current or prior psychiatric diagnoses and they were not Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems (DSM/ICD) diagnoses. The entry for individual # 472 was incomplete - bipolar disorder was listed, but autism was not. No psychiatric diagnosis was listed for Individual #232.	
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	The Monitoring Team reviewed medical monitoring of oral pre-treatment sedation related to medical procedures, for individuals #183 (12/01/10), #228 (09/24/10), #269 (10/27/10), # 278 (09/01/10), #312(01/25/11), #367 (01/28/11), #414 (11/01/10), #472 (11/30/10), #540 (11/29/10 and 12/17/10), #583 (12/01/10), #590 (12/02/10), # 664(02/23/11), #723 (12/02/10), and #782 (09/03/10). Clinical materials reviewed included documentation associated with medical restraints such as restraint checklists, face-to-face assessment & debriefing documents, medical orders, physician specified monitoring schedule, documentation of review activity, any other documentation associated with the restraint use, and integrated progress notes. The Monitoring Team also reviewed medical monitoring during intravenous (IV) sedation related to dental procedures, for Individuals #217 (09/01/10), # 244 (09/29/10), #270	Noncompliance

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	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.	(09/01/10), and # 429 (09/29/10). Clinical materials reviewed included documentation associated with IV dental sedation on specified dates, including restraint checklist/face-to-face assessment & debriefing documents, medical orders, physician specified monitoring schedule, the standard facility protocol for monitoring medical restraint, and any other information associated with the restraint use. The Monitoring Team reviewed PSP information regarding development and/or implementation of plans to minimize use of medical restraint for the individual (including data sheets if a program was developed and implemented) for all eighteen individuals cited above. The Monitoring Team met with Sibylle Graveitt, RN Case Manager Supervisor and Delia Schilder RN, CDDN, CNE, and reviewed how safety monitoring was provided when oral pre-treatment sedation and IV sedation were used during medical and dental procedures. Ms. Schilder and Ms. Graveitt informed the team that when IV sedation was used, nurses accompanied individuals from the residence to the dental clinic and monitored the individual for safety with the Sedation Checklist. Vital signs were obtained per guidelines of the medical restraint guidelines, and monitoring continued in the infirmary, at least until a score of 8 was recorded on the REACT form (a measure of level of sedation, on which higher scores indicated less sedation). Restraint Checklists were not used for IV dental procedures. Ms. Schilder and Ms. Graveitt reviewed procedures used when pre-treatment sedation was used for medical procedures. During on-campus procedures, the DSSLC outpatient medical consultation procedure form was typically used. Restraint Checklists were not used for these procedures. Per information reported by the Facility to the Monitoring Team, there had been no use of oral pre-treatment sedation in the dental clinic during the six months period of September 2010 and February 2011. The Monitoring Team reviewed total intravenous dental sedation (TIVA) monitoring, as follows: Between September 2010 and February 2011 individuals received dental examination under IV sedation 47 times. The monthly frequencies varied from a low of four in January to a high of 11 in November. The monthly average was 7.83 times. The Monitoring Team reviewed each of the 4 cases of IV sedation, Individuals #217 (09/01/10), # 244 (09/29/10), #270 (09/01/10), and # 429 (09/29/10). In each case the procedure was an annual examination. In three of the four cases, (all except #217) pre/active/post sedation checklists were used. Vital signs were obtained prior to the procedure, and 15 minute vital signs were done after the procedure was complete. In all cases a REACT score of at least 8 was documented in the infirmary area. The REACT score was documented in the narrative notes (medical and dental) which were part of the sedation checklist. Documentation was provided during the procedure via the anesthesiology notes. The routine Post Op instructions provided upon completion of the procedure included dismissal from the infirmary when the patient was alert and oriented and for the individual to rest the home for 24 hours. In the fourth case (# 217) dental	

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		progress notes documented IV sedation for the annual exam, but no other documentation was available. For Individuals # 244, # 270, and #429, documentation was also provided from the integrated progress notes which showed nursing follow-up on the home during the 24 hours. One case (Individual #429) contained a note from the day after the procedure that enhanced supervision could be discontinued. In a second (Individual #270) there was nursing follow-up on the unit (without vital signs) on the same day, and two days later, with vital signs. In a third case (Individual #244) nursing follow-up was provided on the home the same evening with vital signs, and twice in the following 24 hours. In one case, (individual #429) the restraint checklist was completed; on that form vital signs were not reported but the form clarified that these were reported on the sedation checklist. DSSLC informed the Monitoring Team that between September 2010 and February 2011 medical pretreatment sedation was used 135 times (the monthly high was 38 uses in December 2010 and the monthly low was 16 in November monthly average was 22.5). While on site, the Monitoring Team requested and reviewed each of the 14 cases of medical pretreatment sedation, listed above. These represented eye examinations (5), imaging studies (4), a gynecological exam, a bone scan, a case of suture removal, an echocardiogram, and a bone density/mammography study (1 of each). In five of the cases, baseline vital signs were located in either the integrated progress notes or on a consultation form. In eight cases, a REACT, rating for the level of sedation, was located. In three case the sedation checklist was completed (all were off-campus procedures). The DSSLC outpatient medical consultation form was completed for seven individuals. Restraint Checklists were not used for these procedures. The Monitoring Team met with Jill Wooten, BCBA, to review procedures in place to establish a desensitization plan or other behavioral interventions for appropriate individuals. Ms. Wooten informed the Monitoring Team about the progress of the dental workgroup that had been meeting to develop guidelines for dental desensitization. This document was in draft form and it relied on the determination by the dental clinic personnel to assess the ability of individuals to cooperate with routine dental procedures. The guidelines described different levels of compliance. Individuals with Type 1 compliance would typically not require sedation. Type II A individuals were assessed as moderately compliant and would typically require oral or IV sedation. Once individuals were identified by the dental clinic, an assessment was made by psychology and a treatment plan developed, to reduce the need of pretreatment sedation. The workgroup recommended that assessments and recommendations would be forwarded to the QMRP prior to the annual PSP, and via the PSP process the required training procedures would be developed and implemented. The four cases of total intravenous anesthesia TIVA sedation were reviewed for	

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		information about efforts to reduce the need for pre-treatment sedation. For individual #217, no information was available. For individual #244 the PSP stated that sedation would be needed prior to dental procedures. There were two training objectives: the first was specific to tooth brushing ability. The individual also had a training objective to take several (up to three) deep breaths to help relax. Training Documentation Request data collection sheets showed that the program was active. For individual #270, the PSP indicated a need for desensitization to minimize pretreatment sedation; the discussion related to that item was that the individual received a desensitization program for tooth brushing. For the fourth individual (#429), the PSP outlined action plans for the individual to be able to walk to the dental clinic without problematic behavior, to greet medical staff and to be able to wait in the dental area without problems. Overall, the Monitoring Team found that nurses assured safety during procedures. However, there was no consistent format for nurse monitoring during medical pre-treatment sedation. Restraint Checklists were not used during medical pre-treatment sedation procedures or IV sedation. Sedation Checklists were used during IV dental sedation procedure. Sedation Checklists were also used for some oral pretreatment sedation for medical procedures, when those procedures took place off campus. When the medical procedure was done on-campus, Sedation Checklists were not used. The DSSLC process to develop and implement plans to reduce the need for pre-treatment sedation was at an early stage of development	
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.	In the previous report of the Monitoring Team, the Monitoring Team found the Facility to be in substantial compliance with this provision. The provision was reviewed to assure continued compliance. At the time of the tour, DSSLC employed three full time staff psychiatrists and one part-time contract psychiatrist, for a total of 3.2 full time equivalent positions, and 258 individuals were under the care of DSSLC psychiatrists. Since the last visit, Dr. Harden's efforts had been redirected from direct service to quality assurance activities. Accordingly, the number of individuals supported by each of the three full time psychiatrists had risen slightly, from 75 to 80 individuals, to about 85 individuals per psychiatrist. In their day-to-day work, the psychiatrists received administrative support from Ms. Brenda Morris and Ms. Devon Wince. The psychiatric assistants provided the psychiatrists with administrative support such as scheduling and support with the preparation of materials and documents for PMRs and other scheduled activities. The psychiatric assistants also prepared summaries of meetings and reports, and they maintained departmental records. A psychiatric assistant also participated in	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		neurology/psychiatry conferences, tracked the information reviewed, and brought that information to the relevant PMR meetings. The assistants also helped the psychiatrists via tracking of labs and other clinical materials. The Monitoring Team found the caseloads of the psychiatrists were at the high end of manageable. On the basis of the documents reviewed, the interviews conducted, the meetings attended, and the observations made, the Monitoring Team found that the level of psychiatric staffing was adequate for DSSLC to ensure the provision of services necessary for implementation of section.	
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.	The Monitoring Team examined psychiatric evaluations completed between September 2010 and Feb 2011 for individuals #4, #12, #14, # 89, #119, #127, #138, #153, #231, #232, #278, # 319, #335, #341, #353, #372, #402, #417, #423, #464, #472, #494, #505, #537, #539, #583, #593, #605, #612, #637, #653, #669, #689, #690, #734, #765, and #772. The Facility implemented use of the SA Appendix B format for psychiatric evaluations, effective 09/01/2010. The Appendix B format was used by the Facility for admission psychiatric evaluations, for annual psychiatric summaries, and for internal referrals/consultation for psychiatric treatment. The Monitoring Team reviewed 37 evaluations. In the paragraphs that follow, 14 evaluations of these are described. <u>Individual #12</u>: The History of Present Illness detailed the pertinent behaviors of concern and identified them as episodic mood lability, impulsivity, anxiety/irritability and aggression. The individual had poor social skills, stubbornness, and limited interest in activity. Past psychiatric history outlined various psychiatric hospital admissions and past medications trials. The psychiatrist noted that past providers had stated that the individual had a fair response to two psychiatric medications but the details were not clear. Developmental, social and family histories were not completed. A limited mental status was included. Axis I diagnoses of autistic disorder and impulse control disorder were made, and the case formulation included the statement that "symptoms of poor social/communication skills, limited interest in activities, frustration intolerance impulsivity, mood lability/irritability cognitive/adaptive deficits etc., meets criteria for axis I and II diagnoses. An outline for initial pharmacotherapy was included, with identification that the targets for treatment with a second generation antipsychotic would be mood lability, impulsivity and irritability. Monitoring Team comments: The evaluation followed the Appendix B format. The evaluation was done within weeks of admission and the absence of detailed developmental, social and family histories was understandable. The psychiatrist chose two axis 1 diagnoses. It was not clear whether the psychiatrist assessed whether the	Noncompliance

#	Provision	Assessment of Status	Compliance
		diagnosis of impulse disorder was needed for symptoms that could not be reasonably linked to autism, or whether the psychiatrist had elected to maintain diagnoses present prior to admission on a provisional basis, pending further evaluations on campus. Individual #119: The assessment was done two days after admission to DSSLC. A helpful review of previous psychiatric medication trials was added to the well summarized section on past psychiatric history. Both were detailed, and contained the key information necessary to construct a meaningful treatment plan for the period following admission, and to lay the groundwork for longer term treatment plans. The area of substance use was properly covered, and in this case there was such a history. Diagnoses were schizoaffective disorder on axis 1 and a characterological disorder on axis II. Monitoring Team comments: The evaluation followed the Appendix B format. The psychiatrist chose to continue the existing diagnosis of schizoaffective disorder, but noted the limited historical evidence regarding DSM criterion A for schizophrenia. The mental status exam commented on the absence of symptoms of psychosis at the time of the examination. For medical illnesses, the psychiatrist referred to the question of whether the individual had a seizure disorder, and this led to specific comments about the choice of medications for possible seizure management and mood stabilization. Such comments set an agenda for future collaboration in the area of overlap between psychiatry and neurology to best integrate ongoing care. There was limited discussion of differential diagnosis and the grounds for the eventual ongoing diagnosis. Given the proximity to admission this was understandable. Individual # 127: The evaluation described repeated episodes of abrupt mood lability, agitation, impulsive aggression, paranoia, auditory hallucinations, and dissociative state. The diagnosis had been changed during the course of the last year to schizoaffective disorder on axis 1 and temporal lobe epilepsy. Medications were reviewed and the psychiatrist commented that one of the medications, Tegretol, was used to target both mood lability and temporal lobe epilepsy. Developmental and social history was provided. The psychiatric summary for the past year outlined what has been learned about the individual's medication response. The case formulation provided a thoughtful summary of the key items in the psychiatric/medical presentation. Diagnoses were schizoaffective disorder, bipolar type, intermittent explosive disorder, mood disorder due to temporal lobe epilepsy. Monitoring Team comments: The evaluation followed the Appendix B format. The psychiatric summary was substantive and quite complete. In the formulation, the psychiatrist stated that the various symptoms cited supported the criteria for axis 1 and axis II diagnoses, without further comment. However, the individual appeared to meet DSM criteria for many diagnoses, and the criteria for several of the diagnostic codes that	

#	Provision	Assessment of Status	Compliance
		were chosen (for example intermittent explosive disorder and mood disorder secondary to epilepsy) were very broad. In that setting, the psychiatrist had considerable discretion about which diagnoses to apply. In such cases, it is best for the psychiatrist to specify the reasons that particular diagnoses were chosen, and if necessary, what symptoms allowed/supported that choice. Individual # 153: The description of current problem section outlined ongoing difficulties with anxiety and frustration, characterized by challenging behaviors such as head banging, finger biting and slamming doors. A history of rumination and stereotypy were reviewed. Medical and surgical histories were well summarized. The individual was treated with Risperdal for psychiatric purposes and with Tegretol and Phenobarbital for epilepsy. The evaluation described that there were no psychiatric medication trials prior to the treatment with Risperdal . The summary of psychiatric care over the past year mentioned the individual's status on symptoms of anxiety, sleep disturbance and stereotypy. A diagnosis of autism was given, and the basis for that diagnosis was identified. The assessment noted that over the past year the individual's dose of the Risperdal had been reduced. Monitoring Team comments: The evaluation followed the Appendix B format, but for baseline psychiatric evaluation, the evaluation was brief. For example, the psychiatrist stated that the individual met criteria for autism, but there was little discussion of the basis for that conclusion. The individual's difficulties with communication and with social skills were mentioned, but their attribution to autism and not to the individual's profound intellectual disability were not. The mention of mild (and uneventful) reduction in the dose of the atypical antipsychotic over the past year addressed issues regarding the direction of psychiatric treatment. The evaluation appropriately provided details of the management of the individual's seizures, and highlighted the need for further discussion between the psychiatrist and neurologist regarding antiepileptic pharmacotherapy. Individual #232: The description of the current psychiatric illness specified that crying spells/isolation were the focus of the psychiatric treatment, as well as the challenging behaviors of self injurious behavior (SIB) and physical aggression to others (PAO). The evaluation added that some of the target behaviors could be the result of medical difficulties. Past history noted a possible genetic etiology, and medical difficulties such as spastic quadriplegia and prematurity. The overall description of the individual's day-to-day life allowed the reader to have a fuller understanding of the individual. The recurrent symptom of trichotillomania was discussed in appropriate detail. The case formulation provided a formulation and possible etiologies for the psychopathology and stated that the "history of developmental delays, cognitive/adaptive deficits, anxiety and maladaptive behaviors meet criteria for Axis I and II diagnoses." Discussion of plans by	

#	Provision	Assessment of Status	Compliance
		the various disciplines followed. Psychiatric Diagnoses were generalized anxiety and trichotillomania, by history. Monitoring Team comments: The evaluation followed the Appendix B format. The evaluation appeared to be written with the assumption that details of the case were known to the reader and it was difficult to consider the evaluation to be a baseline summary of care to date. For example, the psychiatrist presented issues around pending community placement arrangements, without any presentation of the decision to refer the individual for community placement, after prolonged care at the Facility. <u>Individual # 278:</u> The description of the current illness provided the necessary details for the reader to understand the focus of treatment (impaired attention and distractibility, self stimulatory behaviors, such as poking eyes, pulling hairs, mouthing hand, arm, or fist). Discussion of the medical problems was complete, and included mention of three possible seizures in the 1980's. The presentation of the current intracerebral issues was both clear and necessary. The mental status was descriptive and complete. Past psychiatric history and results of previous medication trials were reviewed, and there were helpful comments about the results of the trials. The case formulation/treatment plan was very complete. There was a good discussion of past medication use and there was discussion of a possible taper of Depakote. The diagnosis given was autism. Monitoring Team comments: The evaluation followed the Appendix B format. The evaluation contained all required elements but did not address the reasons that the diagnosis was changed from pervasive developmental disorder (PDD) to autism. <u>Individual # 319:</u> The description of the current illness provided the basis for the diagnosis of autism, by mention of each of the three DSM IV required areas of functioning, and by providing examples of relevant symptoms in each of those areas. The description of current illness identified that aggression was the target of psychotropic medications, and that the individual had tolerated the slow reduction in the dose of antipsychotics well. A significant reduction in the rate of restraint was mentioned. Past psychiatric history was brief but substantive. The review of prior psychiatric medication trials was detailed, and contained very useful information on the outcome of various medication trials. The medical/surgical history was provided, along with details of neurological care. Labs were provided. The developmental and social histories were provided in considerable detail, and the summary of treatment over the past year included the basis for the change in diagnosis from PDD to autism. The case formulation was comprehensive and integrated. For example it clarified that Depakote, prescribed as an anticonvulsant, appeared to have been psychiatrically beneficial. The diagnosis was autism.	

#	Provision	Assessment of Status	Compliance
		Monitoring Team comments: The evaluation followed the Appendix B format. The evaluation provided both the needed information to serve as a psychiatric baseline, and also contained well summarized information on the status of current care and direction for the future. <u>Individual # 417:</u> At the time of the evaluation the individual did not carry psychiatric diagnoses; per the information provided in the assessment, the individual had been treated with Tegretol for a seizure disorder, and had experienced some hyponatremia. The individual was then changed to Keppra. In the months that followed the individual was reported to be more aggressive towards others and had an increased frequency of tantrums. In the past the individual had problems in these areas, but they had diminished in response to the PBSP training program and the individual was weaned off psychotropics. Elsewhere in the report the information was provided that several years ago the anticonvulsant was changed from phenytoin to Tegretol. Whether or not the changes in anticonvulsant happened at the same general time as the improvement in her behavior was not stated. The medication history was provided, as were relevant labs. An extensive developmental and social history was provided. The mental status examination was completed and the case formulation outlined the possibility that the individual's periods of better behavior may have coincided with the times the epilepsy was treated with medications that also served as mood stabilizers. The diagnostic formulation includes several medical "rule out" possibilities. Diagnosis given was intermittent explosive disorder and r/o mood disorder due to (specified) general medical condition. Monitoring Team comments: The evaluation followed the Appendix B format. The evaluation highlighted the value of a good working relationship between psychiatry and neurology, and supports the Facility's continued attention to behavioral side effects – both positive and negative - of medications prescribed for epilepsy. <u>Individual #423:</u> The evaluation provided a good presentation of the individual's difficulties; the medical history listed current conditions, recent labs, developmental and family histories were relevant and the mental status was descriptive. The case formulation was of dementia in the setting of Down syndrome and the treatment recommended (for both an anticholinesterase inhibitor and an NMDA receptor medication) reflected common neurological practice. Monitoring Team comments: The Appendix B format was adapted well to the setting of consultation. Details of dementia workup itself were not addressed in the evaluation; the Monitoring Team understands that at DSSLC the treatment of dementia was handled by psychiatry, with involvement of medicine/neurology as is needed. At the next compliance visit, the Monitoring Team will review with psychiatry and neurology the	

#	Provision	Assessment of Status	Compliance
		joint evaluation and management of cognitive decline in individuals living at DSSLC. Individual # 472: Each of the required components was included. The history of present illness section was presented in the format of a description of the current illness. Psychiatric symptoms of concern were identified as episodic mood lability, anxiety, irritability, impulsivity and hyperactivity. Additional symptoms of stereotypy (including rocking/spinning) and also (SIB) were noted. Current medication details as well as eight past medication trials were noted, and up to date labs comprehensive metabolic profile [CMP], hematology labs, and thyroid stimulating hormone (TSH) were cited. The psychiatric diagnosis was complete in all DSM Axes. On Axis I the individual was diagnosed with bipolar disorder, autistic disorder and attention deficit disorder. The case formulation discussed possible etiologies for the psychopathology, and expanded the discussion to include medical co-morbidities such as epilepsy. The formulation contained the specific symptoms that were linked to each of the medications prescribed at the time of the evaluation, and the psychiatrist discussed specific plans to reduce polypharmacy in the coming period that included the reasons for the selection of medications to be reduced. The status of care by psychology, by the qualified mental retardation specialist, and by the nurse was cited. Diagnoses provided were bipolar Disorder, autism, and attention deficit disorder (ADHD). Monitoring Team comments: The evaluation followed the Appendix B format. The presentation of many complex issues was clear and transparent. As a baseline evaluation, there were a number of items that should be reviewed in more detail: The list of previous medication trials was extremely useful. However, there were few comments on whether the treatments were effective, and why the particular medication was not continued. If available, details would help. The issue of diagnostics in this case was complex and discussion of details was needed. For example, the issue of the way concurrent diagnoses of autism and ADHD should be handled was sufficiently nuanced that guidance on the use is likely to change in DSM V. Similarly, there was considerable clinical overlap between the diagnosis of ADHD and the diagnosis of bipolar disorder. The differentiation of the two was additionally complicated by the use of the diagnosis in an adult, and by the third diagnosis of autism. Individual #494: The evaluation was detailed, and it contained all needed components of the required format. The psychiatrist established in the description of the current psychiatric illness, that the individual has had classic symptoms of psychosis for many years including auditory hallucinations and persecutory delusions. The psychiatrist clarified which of the symptoms of psychosis were present at the time of the evaluation. Past medications were reviewed, and comments about past treatment efficacy were included. Substance use was summarized and active medical problems were listed. Current psychotropic medications/doses were detailed and labs were up-to-date.	

#	Provision	Assessment of Status	Compliance
		Psychotropic medication history was presented in detail, and the description of the symptoms the individual experienced when not medicated (incoherence, grandiosity, paranoia, religious and sexualized delusions) was clear. The psychiatric case formulation was presented in the customary fashion, and was complete. The psychiatric diagnosis was paranoid schizophrenia. Monitoring Team comments: The presentation was excellent and complied with all requirements of the Appendix B format. As in other cases, the initial Appendix B evaluation served as the core/baseline evaluation, and needed to have a complete discussion of the diagnostic choices made by the clinician. In this case the psychiatrist was faced with a history of significant suicidality, yet opted not to make a second diagnosis of an affective disorder. The implication was that the suicidality was secondary to the diagnosis of schizophrenia. The diagnostic choice was reasonable, but the evaluation needed to make explicit the reasons for the diagnostic choice.. Similarly, the evaluation should have included the reason for polypharmacy. <u>Individual # 583:</u> The description of the current illness presented details about the cognitive decline the individual has experienced. Sections on past psychiatric history, prior medication trials were included. Medical and surgical history was consistent with some of the sequela of Down syndrome. Relevant labs were cited. The developmental and social histories were detailed and were helpful to the overall presentation. The mental status was somewhat brief, but informative. The case formulation described the medical difficulties experienced by the individual and outlined why the clinical presentation of cognitive decline was best explained as related to Down syndrome. The evaluation clarified the (re) involvement of psychology and the initiation of a positive behavior support plan (PBSP) in conjunction with treatment with Aricept and Namenda. Monitor comments: The evaluation followed the Appendix B format. The assessment was brief but adequate, and focused on the recent cognitive decline. <u>Individual #605:</u> The appendix B examination was completed on 01/25/2011 in the form of an annual psychiatric summary. Each of the required components was included. The history of present illness section was presented in the format of a description of the current illness. Psychiatric symptoms cited included irritability, agitation, aggression and violence, euphoria, elated behavior, rapid and disjointed speech, illogical and delusional thoughts, high energy level, insomnia, and hallucinations. Past psychiatric history was complete, and the list of prior psychiatric medication trials was both complete and included available information about treatment outcomes. Medical and surgical histories were complete, and laboratory and medical monitoring data included comprehensive metabolic profile, lipids, and chemistries and a hematology profile. There was a discussion about the choice of medication and the reasons for	

#	Provision	Assessment of Status	Compliance
		polypharmacy, side effect monitoring information was complete,. The mental status examination addressed all key areas of functioning. The case formulation provided detailed explanation/justification for the choice of diagnoses. The case formulation integrated the psychiatric status and the complex medical problems experienced by this individual. The diagnosis was bipolar disorder type I with psychotic features. Monitoring Team comments: This psychiatric evaluation was comprehensive and complete. It provided information presented in a clear manner, and explained the diagnosis, the choice of treatments, and the way treatment efficacy was to be judged. This case involved intraclass polypharmacy via the use of two atypical antipsychotics. The annual summary was a good place for inclusion of comments regarding the reasons for the polypharmacy. <u>Individual # 669:</u> The history of present illness described the individual's life long history of aggressive and self injurious behavior. At times the behaviors were unprovoked, but usually were in response to a change in the environment or to seek staff attention. The individual had lived most of his/her life at DSSLC, but the past history provided valuable information on the individual's symptoms in childhood, prior to admission. The assessment contained information on six previous medication trials. Useful information was included about the reasons at least one of the medications was abandoned. Medical history was complete and relevant – the seizure disorder, hypothyroidism, obesity, hyperlipidemia and borderline metabolic syndrome were all pertinent to the behavioral presentation and psychiatric management. The mental status exam was good, and the case formulation was straightforward. The diagnosis given was intermittent explosive disorder. Monitoring Team comments: The evaluation followed the Appendix B format. The psychiatrist addressed in a direct manner that the individual's symptoms were non-specific (SIB and physical aggression); it was clear that the diagnoses used over the years (intermittent explosive disorder, impulse disorder nos, mental disorder nos, etc) were all non-specific, and the past benefits of antipsychotic medications were unclear. The presentation explained the reasons that the PST opted to try targeted medication reductions. Details from the previous year included observations that an increase in propanolol helped aggressive behavior in the afternoon workshop, and that a shift from Tegretol to Lamictal, albeit for the individual's epilepsy, resulted in a worsening of both aggression and self injury, particularly after Tegretol was tapered. <u>Overall comments about the Facility's use of Appendix B evaluations:</u> The Appendix B format for psychiatric evaluations was detailed and demanding. Its first-time use for individuals who have lived at the Facility for many years put demands on facility psychiatrists, since adequate completion of the format required the psychiatrists to	

#	Provision	Assessment of Status	Compliance
		compile summaries on the long term course of illnesses and analyses of treatment efforts made over the years. For many individuals, such summaries had not previously been done. The summaries were needed, however, to serve as repositories of available psychiatric knowledge about individuals for the purpose of guiding future treatment decisions. In addition, initial use of Appendix B required the psychiatrist to outline why various diagnostic choices were made. For example, what was the basis for the assignment of particular DSM diagnoses, and why were certain diagnoses chosen over others when alternative clinical formulations were available when the individual in question met criteria for multiple diagnoses? With the above in mind, the Facility's decision to deploy the Appendix B format for over 250 individuals during a single annual cycle was both ambitious and commendable. For the most part, the Facility had done so successfully, and the summaries reflected the Facility's high level of psychiatric care. Examples of complete and successful implementations of the Appendix B format were individuals #319, #494, and #669. Initial Appendix B evaluation needed to serve as "baseline" evaluations that summarize available psychiatric information about individuals, and the basis for the diagnoses assigned, so as to guide future treatment. In some cases, for example Individuals # 12, #127, #153, #232 and #472, the presentation of the reasons that particular diagnoses were selected needed to be more detailed. In the case of individual #278, there was not a sufficient discussion for a change in diagnosis. In the case of new admissions (such as Individuals #12 and #119) the Monitoring Team agreed with the choice made by the psychiatrist to do the psychiatric evaluation close to the time of admission – in the case of individual # 119 it was done two days after the individual arrived on campus. In such cases, it may not be possible to have complete information at the time of the evaluation, and completion of those items at a later time and their inclusion in the summary for the following year (or in a discharge summary, for a shorter stay) is reasonable practice. The Monitoring Team notes use of format B for internal new treatment/consultation cases (for example, # 583, #423, and #417). In such cases both the clinical issue requiring consultation and the response provided via the evaluation may be more focused, as it was for Individuals #423 and 417. The Monitoring Team concurs with the way the appendix B format was used in these cases.	
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	The Monitoring Team reviewed Reiss Screen booklets and scoring sheets for Individuals #4, #12, #22, #26, #34, #92, #170, #178, #240, #245, #337, #354, #357, #364, #381, #382, #438, 488, #517, #527, #573, #589, #611, #621, #628, #717, #755, #758, #766, and #775. The Monitoring Team also examined Reiss Screen booklets, scoring sheets, and resulting psychological assessments for Individuals # 56, #101, #130, #170, #189, and #510, and Reiss Screens booklets, scoring sheets and related psychiatric assessments for Individuals #89, #402, #417, #423, #464, #583, and #772.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	The Monitoring Team reviewed DSSLC's use of the Reiss Screen for new admissions and for individuals who live at the Facility. DSSLC reported that since 01/01/2010 there had been seven admissions to the Facility. These were Individuals #12, #108, #110, #119, #127, #148, and #494. Reiss screens were completed for five of the seven individuals. One individual (Individual #119) was under the care of a DSSLC psychiatrist and a Reiss Screen was not reported. Individual #148 had been admitted to the Facility several weeks prior to the tour of the Monitoring Team and the Facility did not report a Reiss Screen for that individual. To confirm Facility-wide deployment of the Reiss screen, the Monitoring Team requested the screen's booklets and scoring sheets for thirty individuals who were selected from the list of individuals who lived at DSSLC (every 18th name on the list was selected). All Reiss Screens were provided and examined. The Monitoring Team also requested and received all positive Reiss Screens from the group of individuals who lived at DSSLC and did not receive ongoing psychiatric care. There were six such individuals: Three of the individuals (Individuals #56, #170, and #189) had a second Reiss screen which was negative and no further action was deemed necessary. Three other individuals (Individuals # 101, #130, and #510) had been further evaluated by personal evaluation by a psychologist. None of the three was assessed to be in need of a full psychiatric evaluation. The psychological evaluations of those individuals were examined, and in the opinion of the Monitoring Team, the conclusions of the psychologist were acceptable. Reiss screens were also used by the Facility as part of in-house psychiatric consultation. These were cases where PCPs/PSTs requested the consultation for individuals who lived at the Facility, were not under ongoing psychiatrist care, and had developed a behavior problem for which psychiatric assistance was sought. In such cases DSSLC psychiatrists used the Reiss Screens as part of the clinical psychiatric evaluation; in those cases Reiss Screens were not used to triage the referrals. During the six month period of September 2010 – February 2011 there were seven such consultations, for Individuals #89, #402, #417, #423, #464, #593, and #772. In all cases, full psychiatric evaluations using the Appendix B format were completed. The Monitoring Team reviewed both these Reiss screens and the related Appendix B evaluations. As part of the consultation, psychiatrists gave psychiatric diagnoses which were dementia (2), pica (1), intermittent explosive disorder (2), mood disorder secondary to a general medical condition (1), and a medical problem alone without a DSM diagnosis (1). Three of the seven individuals were recommended for ongoing psychiatric care, including medication. There was only one case (Individual #402) for whom the Reiss Screen was assessed as positive, per the tool's guidelines. In that case the ratings were elevated for aggression and paranoia, and the eventual diagnosis of the consulting psychiatrist was pica.	

#	Provision	Assessment of Status	Compliance
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	The Monitoring Team reviewed materials for Individuals #12, #110, #127, #153, #278, #285, #395, #417, #423, #472, #494, #583, #605, and #62. Clinical information reviewed included demographic information (e.g., profile sheets – photograph and identifying information sheet), social history evaluations, the most recent PSP, and PBSPs, annual medical summaries, active problem lists, the most recent health risk assessment rating – tool and team meeting sheet, the psychiatry section of the record inclusive of the most recent psychiatric assessment, recent MOSES/DISCUS side effects screenings, recent QDRRs, the most recent neurology consultation, recent medical treatment plans, and informed consent forms for all current psychotropic medications. The Monitoring Team evaluated the DSSLC system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. The Monitoring Team's evaluation was based on seven items for this provision that were part of the agreed upon tool. On the basis of records reviews, interviews, and observations made during meetings, the Monitoring Team found that there was good collaboration at DSSLC across disciplines, and that behavioral data was considered in decisions regarding pharmacological treatments. However, the Monitoring Team found that the overall process remained multidisciplinary rather than interdisciplinary. That is, the Monitoring Team found deficiencies in the process that brought together information from different disciplines in the way that joint/interdisciplinary clinical determinations were made, and in the way that the resulting information was recorded and carried forward over time. The Facility had made significant efforts, particularly since the last compliance tour, to generate meaningful combined assessments and case formulations for each individual. In the 3/15/2011 POI, the Facility stated that case assessments/ formulations with specific information about psychological and psychiatric targets would be included in the psychiatric assessments and annual psychiatric reviews, and that psychologists would be encouraged to refer to this information when writing PBSPs. The new format was used for the psychiatric assessment in all 14 cases that were reviewed. In 10 of 14 (71%) cases, the final section of the annual review was a section titled: "Case Formulation and Combined Treatment Plan." The first part of the section was titled "psychiatry," and it provided a detailed discussion of the case and outlined psychiatric plans for treatment. It was followed by shorter sections for psychology, QMRP, and nursing, in which specific actions to be taken by those disciplines were outlined. In the cases of Individuals #278, #319, #417 and #605 (4 of 12 or 29%), a single combined entry was provided. The combined formulations provided integrated information from the various disciplines variably. The Monitoring Team found that in some cases the formulations were integrated and interdisciplinary. In other cases, the formulations were parallel and	Noncompliance

#	Provision	Assessment of Status	Compliance
		multidisciplinary. One of the better integrated case formulations was for Individual #278. It stated that: *"(Individual #248's) developmental disability has been attributed to prematurity. There was a possible impact of encephalitis, at age 6 months, on brain development with subsequent effect of motor, cognitive and adaptive skills. (Individual #248) has a strong family history of mental retardation, suggesting (a) possible hereditary component as well. (Individual #248) experiences impairment in areas of communication, social skills, and impulse regulation. (Individual #248) also displays stereotypical/non functional body movements and fixation on certain objects and activities. These behaviors/symptoms are the basis for (the) change in diagnosis to Autistic Disorder. (Individual #248) has a history of being maintained with the help of supportive environment and positive behavior support plan and without psychotropic medications. (Individual #248) does not display any psychiatric symptoms at this time that requires medication management. Depakote was prescribed in the past for aggressive behavior along with other psychotropic medications, but aggressive behaviors appear functional in nature at this time. Recent increases in rate of physical aggression to others (with low intensity) appeared related to environmental factors (change in seating arrangements at home and work with lack of adequate personal space) and health problems rather than a change in baseline mood.* Treatment assignments that followed centered on behavioral and medical interventions, while the psychiatrist focused on a taper of remaining medications that had been deemed ineffective. In summary, the formulations were most helpful when the summary provided a brief summation of the individual and his/her behavioral presentation, followed by efforts to differentiate or delineate as much as was possible, the contributions of learned behavior, psychopathology, medical illness (if present), and other clinical processes. Such understandings – even if they were necessarily not definitive and they represented no more than the shared working understandings of the treatment team - will help the Monitoring Team and others understand how DSSLC constructed the clinical treatment for individuals and why particular treatments were assigned. During the tour the Monitoring Team inquired about the Facility's decision to embed the combined formulation at the end of the annual cycle in the psychiatric update. The topic was discussed in some detail in a meeting with the Facility lead psychiatrist, who reflected that a large majority of the individuals served had lived at the Facility for many years and the annual summary was natural place in the annual cycle for reflection and summation. Accordingly, the annual review was a time when the psychiatrist had already consulted with the psychologist and other PDT members, and was able to put the overall understanding of the individual in writing in the annual review, on behalf of both the psychiatrist and other PST members. The Monitoring Team, however, had remaining	

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		questions regarding how the interdisciplinary assessment process would unfold for individuals who were new to the behavioral services group (such new admissions and internal referrals via consultation), for whom the combined case assessment was particularly important. As reviewed under provision J6, the psychiatric evaluations for Individuals #12 and #423 appeared to have taken place too early in the clinical process to have allowed a full interdisciplinary formulation. It is possible that different clinical processes are needed for the different clinical circumstances that require interdisciplinary combined case assessments.	
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.	Materials reviewed for this provision were for Individuals # 119, #127, #153, #232, #278, #319, #417, #472, #494, #583, #605, #669: Information reviewed included demographic information (e.g., profile Sheet – photograph and identifying information sheet), social history evaluation, the most recent PSP and PBSPs, annual medical summary, active problem list, most recent health risk assessment rating – tool and team meeting sheet, the psychiatry section inclusive of the most recent admission or annual psychiatric assessment, most recent MOSES/DISCUS side effects screens, recent QDRRs, most recent neurology consultation, informed consent forms for all current psychotropic medications. The provision relates to PBSP development. Previous reviews by the Monitoring Team had established that as a general matter, all individuals who lived at DSSLC and who receive psychotropic medication had PBSPs. In the course of reviewing materials for this provision, however, PBSPs were requested but were not provided, for Individuals #12 and #423. For Individual #12, the Active Record was missing the PBSP. Each of these individuals received psychotropic medications, but in each case the treatment was started only recently. The omission was detected after the completion of the tour. It is possible that a clerical/administrative issue explains the absence. Alternatively, it is possible that there is a delay between the initiation of the medication and the development of the PBSP. Provision J8, discussed above, required the Facility to provide combined (interdisciplinary) assessments and case formulations. Once such formulations are in place, the PST can respond to requirement of provision J9, to determine the modalities of treatment that will best serve the individual – behavioral, medication or other interventions, in combination or alone. PBSPs then describe the manner in which treatment is provided, with a focus on psychiatry and psychology. DADS psychology policy and DSSLC psychology procedures specified the medication-related information that should be included in PBSPs. PBSPs of the twelve individuals listed above were examined by the Monitoring Team, for the presence of required medication-related information in the PBSP	Noncompliance

#	Provision	Assessment of Status	Compliance
		1. Details of prescribed psychotropic medications: PBSPs for all 12 individuals reviewed contained the names of the medications that were in place when the PBSP was written. In one case (individual #127) the PBSP was inconsistent; in one part of the PBSP the medications identified were Seroquel and Tegretol, but in another part the discussion was for Trileptal. In this and many other cases, the names of the medications were imbedded in the text of the PBSP; the PBSP format that was in use at DSSLC did not have a psychotropic medication section in which core information about the medication (medication name, rationale/reason for medication use, expected results, symptoms/behavioral characteristics for monitoring treatment efficacy, etc) was outlined. This may have contributed to the kind of difficulty noted here. 2. The psychiatric diagnosis or behavioral–pharmacological hypothesis , and data, support the need for the medication: Three (25%) of the individuals had information of diagnosis in the PBSP that supported the need for the medication. These were Individuals #417 #583 and #605. In PBSPs for three additional individuals (25%), there was partial information. These were Individuals #119, #232 and #669. In the case of Individual #669, for example, the psychiatric diagnosis was mentioned but not discussed and there was no discussion of the relationship between the individual's diagnosis and the challenging behaviors exhibited. There was some speculation about the effects of the medication (for example, a change in the individual's tolerance of aversive stimuli) and observations that the individual has little capacity to defer gratification. In the remaining six cases (50%), needed information was not provided. These were Individuals #127, #153, #278, #319, #472, and #494. In the case of individual #127, the PBSP stated "the use of psychotropic medication will help in the management of symptoms related to (the individual's) current psychiatric diagnosis." In the case of individual #278 the PBSP stated that "(given) the severity of aggressiveness, the medications are judged to be an effective treatment for the individual's impulse control difficulties." In other cases there was no information. 3. Psychiatric symptoms or behavioral characteristics that were monitored to assess drug efficacy (behavioral markers) and by whom, when and how the monitoring occurred: In 3 cases (25%) information was provided about the behavioral characteristics. These were Individual #278 (sleep and irritability), Individual #417 (aggression and being "impatient when waiting for needs to be met" for the diagnosis of intermittent explosive disorder, and crying for no obvious reason for mood disorder), and Individual #517 (dementia). In four cases (33%) partial information was provided. The four cases were Individual #153 (brief description given of the three areas of symptoms upon which the diagnosis of autism was made, but not the symptoms targeted by the medication or their relationship to the individual's disorder), Individual #232 (the text of the identification of the problem implied agitation/ trichotillomania and agitation, but this was not clear,) Individual	

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		#472 (anxiety and hypomania symptoms were discussed as target symptoms used to track the individual's disorder, but these were not the symptoms listed on the psychiatric tracking in the quarterly review, and they were different from the symptoms mentioned on the psychiatrist's annual summary), and Individual #605. In five cases (Individuals #119, #127, #319, #494 and #669), needed information was not given. For example, in the case of individual #669, there was detailed discussion of the individual's physical aggression and self injurious behaviors, but neither the psychiatric symptoms nor specific behavioral characteristics that were the focus of the medication were identified. 4. Most likely side effects of the medication: In three cases (25%) the needed information on common side effects was provided. These were Individuals #153, #583, and #605. In seven cases (58%), needed information on the likely side effects of each medication(s) was either not provided or the reader was referred to the pharmacy or to an external monograph. These were Individuals #119, #127, #232, #319, #472, and #494. For Individuals #278 and #417 (two cases, 17%), side effect information was provided, but it was different from the information that was listed on the consent form/medication plan. Both lists were correct but served different functions. In the medication plan/consent form psychiatrists had identified limited number of the most likely/relevant side effects for the individual. That list focused on the individual and his/her particular healthcare circumstances, and that is the information that should be cited in the PBSP. It is a good practice to also include an additional reference to a broader discussion of the medication and its side effects, for example via the micromedix database, but that reference should not replace the information. 5. Projected time line for the therapeutic effects of the medication to occur: This item was not addressed in any of the PBSPs reviewed. It was included in the newly developed psychiatric medication treatment plan form. 6. The possible risks of not giving the medication(s) outweigh the risks of receiving them, substantiated by data when possible: Generally, each of the PBSPs reviewed included a statement that the risk of the untreated problem was greater than the risk of medication side effects. But relevant details (per the guidance above) were sometimes lacking. For example, for Individual #472 the risk of not giving the medicine was stated to be "the risk of untreated mental disorder and related behavior." A different concern was noted for Individual #119. In the PBSP for that individual, symptoms of concern were cited, but they were different than the symptoms cited by the psychiatrist as the focus of treatment. 7. A medication plan is included that states criteria for change in medication in response to changes in the individuals symptoms (the medication is effective in reducing symptoms/target behaviors, there are no changes in symptoms/target behaviors, or the symptoms/target behaviors increase: Many of the PBSPs reviewed stated that the PST will recommend medication reduction when challenging	

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		behavior is reduced by a specified amount,. With one exception, however, none of the PBSPs reviewed addressed what would be done if the symptoms remained unchanged or increased. The notable exception was Individual #583 who was newly treated for dementia. In the "plan of alleviation" section of the PBSP the writer noted, "As the individual is diagnosed with dementia, it is not appropriate to place behavioral goals for decrease of (the individual's) target symptoms. This program was designed to help maintain functioning, as much as possible, thus the lack of improvement may not be a sign for inadequate treatment, prevention and management of (the individual's) target behaviors, rather a sign of (the individual's) psychiatric stability. "	
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.	Medication plans (provided in the new format), and consent for psychotropic medication (also in the new format), were reviewed for the following Individuals: # 12, #110, #153, #285, #278, #395, #417, #423, #494, and #583. In the comments for provision J9 above, the Monitoring Team has confirmed that a " risk vs. risk section" was included in PBSPs. However, PBSPs did not identify the process by which the determination is made. In particular it is not clear how or whether the medical personnel identified in the requirement participated in the process of determination. Additionally, it was not clear how or whether deliberations about reasonable alternative strategies were conducted, before the non-emergency administration of the psychotropic medication. The new medication plan format provided a risk/benefit analysis. The process by which the treatment plan form was completed was described to the Monitoring Team by the lead psychiatrist. The general plan was typically developed, and the medication plan form filled out by the psychiatrist, during a Psychiatric Medication Review (PMR) meeting. Participants in the PMR typically included the nurse, although typically not the PCP. PCP inclusion in the required review was achieved by way of a telephone call, made by the psychiatrist. The Monitoring Team reviewed the medication plans form for the ten individuals identified above. In the case of Individual #278, the nurse did not attend the meeting. During the tour the Monitoring Team did not ask about whether treatment strategies were discussed. It was possible that they were, but this was not clear from the written record (although it was implied by wording on the medication consent form, also filled out at the time of the PMR). There did not appear to be a process in place to include the case manager nurse in the discussion if s/he was not present at the meeting. During the next tour the Monitoring Team will review further to assure that procedures are in place to assure that required individuals participate in decision making, and that	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		the participation is documented.	
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.	Information reviewed for this provision included lists provided by the pharmacy of the facility wide use of various medications including anticonvulsants used for both psychiatric and neurological indications, lists of individuals identified to have polypharmacy per the definition of the SA, and minutes of the polypharmacy and P&TC committees, for the period between September 2010 and February 2011. The Monitoring Team reviewed how DSSLC tracked and monitored psychiatric polypharmacy at the facility level. Polypharmacy was identified by pharmacist in the QDRR. It was discussed at Health Services Team meetings and 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. The monthly polypharmacy meeting was an overall review regarding the rationale and planning for management of individuals identified to have polypharmacy. 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. The Monitoring Team found that review of polypharmacy continued to be 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 that in the monthly polypharmacy reviews, all individuals who had antipsychotic polypharmacy were reviewed each month, followed by periodic reviews by the psychiatrists of individuals who had other forms of polypharmacy.	Substantial Compliance
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	Information reviewed for this provision was for Individuals #12 # 119, #127, #153, #232, #278, #319, #417, #423, #472, #494, #583, #605, #669. Clinical materials reviewed included annual medical summaries, active problem lists, most recent health risk assessments – tool and team meeting sheet, the psychiatry section inclusive of the most recent admission or annual psychiatric assessment, most recent MOSES/DISCUS side effects screening, recent QDRRs, and the most recent neurology consultation. The system used at DSSLC for side effect screening was reviewed at the time of the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	the individual's current status and/or changing needs, but at least quarterly.	previous tour of the Monitoring Team and had not changed. During the current tour the records identified above were reviewed for the inclusion of MOSES and DISCUS forms and they were properly completed. Additionally, the Monitoring Team was provided with lists of all MOSES and DISCUS administrations over the past six months. At the time of the last tour the Monitoring Team recommended that the Department of Psychiatry should maintain a list of individuals who were known to have tardive dyskinesia. Such a list was requested for the current tour. During the tour, the Monitoring Team discussed with DSSLC psychiatrists what consultation procedures were available to DSSLC for monitoring difficult to classify movements disorders, including tardive processes such as dystonia and akathisia (for example, Individual # 395). Services were provided via the general neurology clinic. In the opinion of the Monitoring Team, the overall system for monitoring side effects in place at DSSLC was adequate. The Monitoring Team will continue to verify that screenings are being completed. A number of remaining facility level issues will be reviewed at the next tour. These include details of staff training for dyskinesia monitoring, and how the Facility will monitor psychotropic medication use of individuals known to have dyskinesia.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in	Information reviewed for this provision was for Individuals #12, #110, #153, #285, #278, #395, #417, #423, #494, and #583. Clinical materials reviewed included medication plans (in the new format), consents for psychotropic medication (also in the new format), and recent PMRs. As outlined in the 03/15/2010 DSSLC Plan of Improvement (POI), the Facility had started to use medication treatment plans. A Medication Plan form was filled out whenever a new non-emergency psychotropic medication was started and it was updated at the time of the annual psychiatric review. In order to assess compliance with the provision, the Monitoring Team examined the Medication Plan form, and examined its use for the individuals listed above. The manner in which the treatment's efficacy was monitored in subsequent PMR appointments was also reviewed. The Medication Plan form contained lines for the items required by provision J13 for medication treatment plans. These were the name of the medication, the psychiatric diagnosis, the target symptoms, planned details for treatment monitoring, the time line for expected results, and the risk benefit assessment. A pertinent additional requirement for medications was that the medical record should document the rationale for the medication (monitoring tool accepted by the parties, SA provision J3 item 1f). All Medication Plans contained required information for the name of the medication,	Noncompliance

#	Provision	Assessment of Status	Compliance
	the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	diagnosis, time line for expected results, and risk benefit analysis. Some individuals' medication plans included a statement about rationale but this was not always substantive. For example, for Individual #494 the rationale for the use of the medication Saphris was "to see if the patient would benefit from Saphris." Elsewhere in the same form, the target symptoms of delusions and hallucinations were identified. This suggested to the Monitoring Team that the intended rationale was that the then-present antipsychotic treatment had not provided adequate relief from symptoms of psychosis, and the individual could benefit from a trial of a different antipsychotic. The "monitoring' section often failed to address details regarding how treatment efficacy would be assessed. For example, some symptoms might be monitored by the psychiatrist informally via mental status exam in the clinic, while other symptoms might be better assessed by the psychologist using formal data collection techniques. Symptoms for which formal and ongoing monitoring outside the clinics was needed should be identified and procedures established. For example, for individual #147 the psychiatrist properly identified that the individual would be monitored for mood instability, impulsivity and aggression. But in the quarterly PMR, formal tracking was provided only for aggression and impulsivity. It was not clear how mood was assessed. It could have been done, for example via mental status examinations by the psychiatrist at PMRs, by formal data assessment techniques provided by the psychologist, or both. Another example was Individual #153, treated for insomnia with the hypnotic trazodone. For that individual, there were two data sections –one for psychiatric symptoms and for general behavioral measures. It was not clear how the psychiatrist and psychologist decided to include a measure of insomnia in the general data, and not the psychiatry. In order to meet the requirement for how the monitoring will occur, psychiatrists should consult with psychologists regarding which psychiatric symptoms will be formally tracked by psychology, and those items should be supported in the customary fashion for behavioral tracking, including the utilization of baselines period when needed, the identification of standard psychopathology tracking tools when these are utilized, and the provision of operational definitions for assessment made by psychological staff. Outstanding difficulties notwithstanding, the Monitoring Team has observed a good start to the new process and there was progress in the area of medication tracking.	
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	Information reviewed for this section was for Individuals #12, #110, #153, #285, #278, #395, #417, #423, #494, and #583. Documents reviewed were the consents for psychotropic medication and related medication plans. DSSLC had revised the form used to obtain informed consent from guardians/legally	Noncompliance

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	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.	authorized individuals. The Monitoring Team examined the new form and reviewed the process by which informed consent was obtained. The consent process was initiated by the prescribing physician, typically at a PMR. Either during the PMR or shortly thereafter, the psychiatrist filled out the consent form, which included the diagnosis, the medication, and pertinent side effects. Either at the time of the PMR or shortly thereafter, the psychiatrist spoke with both the primary care physician and then with the guardian. The consent form indicated that any appropriate alternative procedures were presented to the Legally Authorized Representative (LAR.) Telephonic (interim) consent was documented by a witness. The form was then referred for approval by the Human Rights Committee (HRC). Telephonic (interim) consent was available and its use was documented on the form. In eight of the ten consents, the new form was used. Two of the consent forms (both from November 2010) used the old form that did not contain side effect information. DSSLC has just started using the new process, and there are not yet examples of its use for restrictive procedures other than medications. Additional sampling will be made during the next tour. Furthermore, integration of use of psychotropic medications into the Positive Behavior Support Plan (PBSP) was not complete. Weaknesses in the information provided in the PBSP contributed to a finding of noncompliance for Provision K.9.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	Materials reviewed for assurance of compliance with provision J15 included review of list of dual purpose medication (neurology and psychiatry) that was prepared by the pharmacy. Minutes of the neurology/psychiatry conference attended by the Monitoring Team are described below. DSSLC continued to enhance collaboration between psychiatry and neurology via scheduled meetings between each of the staff psychiatrists and the consulting neurologist. These conferences were held monthly, at the beginning of one of scheduled on-site neurology clinics. The conference length varied but was typically about an hour. It was attended by the neurologist, one of the psychiatrists, the neurology clinic coordinator and one of the psychiatry assistants. The three staff psychiatrists attended the conferences on a rotating basis, so that each psychiatrist consulted on a scheduled basis with the neurologist, roughly quarterly. The psychiatrist chose in advance which individuals were to be reviewed, the clinic coordinator assured that the relevant clinical documents were available to the physicians, and the psychiatry assistant took notes on the discussion and prepared minutes, to ensure needed follow-on and follow-up. In addition to participation in the conferences, the psychiatrists were free to consult with the neurologist on an as-needed basis during any given neurology clinic, and the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Monitoring Team was informed that they did so. During the visit of the Monitoring Team a neurology/psychiatry conference was scheduled and the Monitoring Team attended the conference. Five individuals were reviewed, and the Monitoring Team was informed that the topics discussed were typical for the conference. These were as follows: 1. Individual # 313 was reviewed since the Individual took both Depakote and Tegretol for both psychiatric and neurological purposes. The individual had a seizure, the dose of Tegretol was adjusted, and the two physicians discussed the ramifications of the dose change. 2. Individual # 370 was reviewed since the Individual took the anticonvulsant Depakote for seizures and the anticonvulsant Tegretol as a mood stabilizer. 3. Individual #321 was reviewed since the Individual took both Depakote and Tegretol for dual purpose. Relevant laboratories and the relevant seizure history were reviewed, as was the psychiatrist's decision to taper the dose of Depakote due to side effects. The two physicians concurred on the decision to continue with the taper of Depakote. 4. Individual # 353 was reviewed since the Individual took Depakote for dual purpose. The individual had not had a seizure since 2007 and need for continued neurological care was reviewed. 5. Individual #664 was reviewed due to a seizure in January 2011, for which the individual was seen in the neurology clinic on in February 2011. The two physicians discussed plans for continued care On the basis of examination of the records, discussion with the psychiatrists, and observations made at the time of the clinic the Monitoring Team found that coordination between psychiatry and neurology and psychiatry remained strong and DSSLC remained in compliance with the provision of the SA.	

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

1. The Facility should clarify procedures used for medical restraint monitoring, when pretreatment sedation for medical procedures is deemed necessary.
2. Facility psychiatrists should assure that initial Appendix B psychiatric evaluations should include, when clinically necessary, the considerations regarding why particular diagnoses were selected and the DSM basis of those considerations. It is particularly important to do so when there are several clinically viable formulations available to the psychiatrist. Additionally, whenever it is practical to do so, each evaluation should provide a summary of the efficacy of treatment trials provided over the years, so as to guide future treatment efforts.
3. The Departments of Psychiatry and Psychology, with input from other clinical departments, should continue to develop clinical processes to support interdisciplinary assessments and case formulations, for ongoing cases and new admissions.

4. The Departments of Psychiatry and Psychology, should improve the manner in which PBSPs communicate the details of psychotropic medication treatments.
5. When new psychotropic medication is proposed, the psychologist and psychiatrist should decide jointly how treatment efficacy will be determined. In particular, both should be clear about which symptoms should be tracked with formal data collection techniques. Those preferences should then determine the data that is collected and presented at psychiatric medication reviews, to support psychiatric treatment. Symptoms for which formal and ongoing monitoring outside the clinics is needed should be identified and procedures established.
6. In order to meet the requirement for how the monitoring will occur, psychiatrists should consult with psychologists regarding which psychiatric symptoms will be formally tracked by psychology, and those items should be supported in the customary fashion for behavioral tracking
7. When a new psychotropic medication is proposed, the rationale for the use of the medication should be stated, to assure that there is concordance between the clinical diagnosis and behavioral symptoms selected for treatment monitoring.
8. When a new psychotropic medication is proposed, the list of pertinent possible side effects for medications that is on the consent for new medications and the list that is cited in the PBSPs should be the same. That list should not be too lengthy and uncommon side effects need not be cited – Patient Education Monographs provide fuller information.
9. When items on the new medication plan and informed consent are initiated by telephonic contact, the person obtaining the information should be identified, for example via initials.
10. When clinically appropriate, a representative of the psychiatry group should participate in the PST meetings that are held when an individual experiences more than three episodes of restraint in 30 days.
11. The Facility should consider having a DSSLC psychiatrist review Individual #381, to assess whether psychiatric treatment might reduce the use of restraints.
12. APLs should include current psychiatric diagnoses

The following are offered as an additional suggestion to the Facility:

1. The needs identified in recommendation #4 above can be accommodated in a number of ways. One possibility is to have a psychotropic medication section in the PBSP, in which the various items identified in the medication treatment plan can be located. As discussed during the tour, however, a new format for the PBSP had just been put in place. The format in use can accommodate the needed medication information, and this can be done using a number of schemas. Assuming that the current format will be retained, the Departments of Psychology and Psychiatry should consider providing guidance to clinicians regarding linkage between particular PBSP sections and the various medication related items.
2. While most information related to new medications are listed in the psychiatrists' medication plans, side effects of the medication are listed by the psychiatrists elsewhere – on the medication consent form. To facilitate accurate inclusion of medication related information into the PBSP, the Department of Psychiatry could consider the option – at the obvious cost of duplication of information - of listing the main medication side effects on both the medication treatment plan and the consent form.

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. Denton State Supported Living Center (DSSLC) Plan of Improvement (POI), 03/25/2011 2. Facility Policies and Procedures 3. Minutes for the Behavior Services Peer Review Committee meetings and departmental meetings. 4. Preliminary materials for Competency-Based Training. 5. Documents that were reviewed included the annual PSP, PSP updates, Special Program Objectives (SPOs), Positive Behavior Support Plans (PBSPs), structural and functional assessments (SFAs), 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, task analyses, and behavioral and functional assessments. All documents were reviewed in the context of the POI and included the following individuals: #19, #79, #107, #108, #110, #119, #123, #127, #134, #183, #208, #226, #229, #232, #238, #240, #250, #255, #297, #306, #319, #337, #367, #381, #399, #413, #460, #483, #494, #506, #537, #539, #540, #557, #565, #609, #624, #629, #664, #669, #687, #753, #772, and #774 **People Interviewed:** 1. Randy Spence, MS – Director of Behavior Services 2. Rick Smith, PhD, BCBA-D – Behavior Services consultant 3. Jill Wooten, MS, BCBA – Psychologist 4. Katy Acheson, MS, BCBA – Contract Psychologist 5. Bryan Lovelace, MS, BCBA – Psychologist 6. Leigh Rogers – Psychology Assistant 7. Frank Padia – Director of Program Coordination 8. Shillonda Perkins – QMRP Coordinator 9. Leslie Clark – QMRP 10. Kizzy Mickels – QMRP 11. Julie Kuester – QMRP 12. Linda Ford – Director of Active Treatment 13. Ken Horstman – Director of Residential Services 14. Ynez Coleman, RN 15. One program staff in Employment Training Center (ETC) 16. Carmen Stearns 17. John Russell – Wellness Program instructor 18. Approximately 20 direct care staff **Meeting Attended/Observations:** 1. PSP for Individual #413 (3/29/2011) 2. Restraint Reduction Committee (3/30/2011) 3. Section K Committee Meeting (3/30/2011)

	4. Conducted observations in Residence 504, 505, 508, 522, 523, 524, 525, 526, 527, and 528 (3/28/2011 – 3/31/2011) 5. Conducted observations in the Employment Training Center, Gymnasium, ICD, and Job Training Center (3/28/2011 – 3/30/2011)
	Facility Self-Assessment: At the time of the site visit, DSSLC reported that no provisions of Section K of the SA were in substantial compliance. DSSLC did report that progress had been achieved in relation to the expanded availability of BCBA credentialed staff and contract employees, the implementation of new data collection forms and procedures, revised forms and procedures for behavior and psychological assessment, and the collection of IOA probes and assessment. The Monitoring Team was in agreement that progress had been achieved in these areas.
	Summary of Monitor's Assessment: Observations, interviews and record reviews were conducted on-site at DSSLC from 3/28/2011 through 4/1/2011. Record reviews continued off-site for several days following the site visit. Although no provisions of Section K of the SA were found to be in substantial compliance, it was noted that DSSLC had achieved considerable progress in many areas. Staff, documentation, and achievements by individuals living at the Facility reflected the diligence and determination of the Facility to achieve compliance. DSSLC continued to display multifaceted efforts toward enhancing the skills and abilities of the Behavior Services staff. The number of Behavior Services staff participating in BCBA classes increased from three to 12. Peer review was enhanced by the adoption of a specific rubric for submitted materials with the resulting feedback geared toward enhancing staff competence. In addition, competency-based training targeted toward new and selected incumbent Behavior Services staff was implemented. Of particular note was the Psychologist ABA Competence Training. This training was targeted toward new and selected incumbent Behavior Services staff, and was taught by faculty and staff of the University of North Texas. The training required 4 hours per day, four days per week over a twelve-week period. Such effort was a very positive step initiated by DSSLC. It was also noted during the site visit that progress was made by DSSLC in relation to data collection. New data collection forms that allowed for more diverse measurement strategies were implemented. In addition, Behavior Services staff had begun the first phase of a strategy to measure interobserver agreement (IOA) for behavior data. Both the data forms and the collection of IOA data were very well planned and held the potential for substantial benefit and improvement. Progress was noted as well in the assessment of behavior and the development of PBSPs, as well as the format and process for Psychological Assessments and Functional Assessments. Combined with enhanced PBSPs and the previously discussed efforts in the area of measurement and data collection, the potential for truly integrated and cohesive behavioral assessment and intervention was substantially enhanced.

	Despite the effort put forth by DSSLC and the indications that the Facility was making substantial progress toward compliance with Section K of the SA, several areas of deficit were evident. PBSPs continued to lack sophistication and did not conform to current standards of practice in applied behavior analysis. By the Facility's own measure and supported by Monitoring Team observations, only slightly more than half of PBSPs met the Facility's own standards of practice. Neither PBSPs nor data graphs reflected the basic conditions necessary to allow for the determination of treatment efficacy. In several cases, the strategies for strengthening replacement behaviors were either not implemented by staff or reflected a lack of data. Based upon the information obtained during the most recent site visit to DSSLC, improvement was being achieved. There remained, however, considerable amounts of work to be completed before substantial compliance with Section K of the SA would be possible. **For Provision K.1:** This provision was determined to be not in compliance. DSSLC was aggressively pursuing BCBA credentialing for the Behavior Services employees. At the time of the site visit, however, only 30% of the staff were BCBAs. Of the PBSPs developed since the previous site visit, only 20.2% were completed by a BCBA. **For Provision K.2:** This provision was determined to be not in compliance. The Facility employed a Behavior Services director with broad experience in intellectual disabilities and applied behavior analysis. Mr. Spence is not a licensed psychologist and had opted to pursue board certification in behavior analysis. Once he completes BCBA credentialing, the Facility will be in substantial compliance with this provision. **For Provision K.3:** This provision was determined to be not in compliance. The Facility had a system in place for both internal and external peer review. The elements of the peer review process reflected acceptable practice but there were delays in responding to the peer review comments by revising the PBSP, and the reviews had yet to produce broad improvements in the PBSPs implemented. **For Provision K.4:** This provision was determined to be not in compliance. A new data collection form had been introduced recently. Weaknesses in the designs of PBSPs, however, limited the usefulness of data and prevented data-based decisions for many individuals. **For Provision K.5:** This provision was determined to be not in compliance. A new assessment process and format introduced meaningful changes. Well below half of the sampled assessments documents, however, met all standards for compliance with the SA. **For Provision K.6:** This provision was determined to be not in compliance. Based upon the information presented in K5, minimal documentation in the record reflected assessment findings that were demonstrated to be current, accurate or complete. **For Provision K.7:** This provision was determined to be not in compliance. 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.

	For Provision K.8: This provision was determined to be not in compliance. Records provided by DSSLC did not include assessments, progress notes or treatment data pertaining to counseling services for these individuals. Therefore, it was not possible to determine progress or compliance in this area. **For Provision K.9:** This provision was determined to be not in compliance. Although improvements were noted in PBSPs, only a small number of sampled PBSPs satisfied all items necessary for compliance with the SA. **For Provision K.10:** This provision was determined to be not in compliance. Data graphs continued to lack specific key elements and were limited in usefulness. **For Provision K.11:** This provision was determined to be not in compliance. Improvement had been made in simplifying the instructions provided to staff regarding behavior interventions. Several PBSPs still included complex language likely to hinder staff comprehension. At the time of the site visit, DSSLC did not routinely assess the implementation of PBSPs. **For Provision K.12:** This provision was determined to be not in compliance. At the time of the site visit, DSSLC was in the process of developing and implementing a system of competency-based training. As the training had not been fully implemented, it was not possible to assess progress in this area. **For Provision K.13:** This provision was determined to be not in compliance. At the time of the site visit, DSSLC employed six staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 90 individuals residing at the Facility and fell far short of the required ratio of one BCBA for every 30 individuals.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>K1</td><td>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</td><td>The number of new and revised PBSPs completed since 10/01/2010 (the end of the previous site visit) was 173. Of those PBSPs, 74 were completed by a BCBA. Based upon those numbers, 43% of PBSPs or PBSP revisions since the previous site visit were completed by a BCBA. During the six-month period prior to that, 224 PBSPs were developed or revised, with 31 of those PBSPs (13.8%) completed by a BCBA. Therefore, the number of PBSPs developed or revised by a BCBA increased a modest 29% since the last site visit.

DSSLC also increased the number of Behavior Services staff who held board certification in applied behavior analysis or who were working toward board certification.

<table>
<tr><td></td><td>10/2010</td><td>3/2011</td><td>Change</td></tr>
<tr><td>Total number of BCBAs</td><td>5 (25%)</td><td>6 (30%)</td><td>5%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	<table><tr><td>Total staff enrolled in BCBA classes</td><td>3 (20%)</td><td>12 (86%)</td><td>66%</td></tr></table> It was noted during the previous site visit that DSSLC had conducted an applied behavior analysis "boot camp" for all Behavior Services staff lacking board certification in applied behavior analysis. That effort had been expanded into the DSSLC Psychologist ABA Competence Training course by the time of the current site visit. This training was targeted toward new and selected incumbent Behavior Services staff. The course was taught by faculty and staff of the University of North Texas, including Richard Smith, PhD, BCBA; Katy Acheson, MS, BCBA; and Carla Smith, BS, BCABA. The training required 4 hours per day, four days per week over a twelve week period. Any participant who acquired three absences was required to retake the entire course. A review of the training materials and completion criteria reflected that participants would be exposed to and acquire competence in the basics of applied behavior analysis. During the previous site visit it was noted that DSSLC needed "considerably more progress" in the area of ensuring that Behavior Services staff were demonstrably competent in applied behavior analysis. Although 18 to 24 months were likely to be needed before board certification could be completed by most Behavior Services staff, it was evident that DSSLC had acted diligently and aggressively toward this goal.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	At the 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. Mr. Spence is not a licensed psychologist and, at the time of the site visit, was actively continuing 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 compliance.	Noncompliance
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 current site visit, continued to implement the internal and external peer review process noted during previous visits. The internal peer review committee was coordinated by the Behavioral Services staff members that are board certified as behavior analysts. A review of committee minutes and discussions with staff revealed active application of a sound peer review model. During the previous site visit, it was evident that at least some external peer review was not completed prior to the implementation of a PBSP. At the time of the current site visit, 100% of PBSPs implemented during the previous 6 months had received full internal and external peer review.	Noncompliance

#	Provision	Assessment of Status	Compliance
		External peer review is performed by Ed Hutchison, PhD, BCBA. Dr. Hutchison reviewed 100% of PBSPs submitted for internal peer review by the PBSC. Submissions were reviewed on a monthly basis and returned to the PBSC prior to the date scheduled for internal peer review. PBSPs reviewed by Dr. Hutchison were rated on a checklist. Feedback was provided to the submitting psychologist in the forms of checklist scores, written comments, and recommendations. In addition, Dr. Hutchison also attended the PBSC meetings frequently to provide additional verbal feedback. External peer review included the use of a checklist that targeted 8 areas of competence: 1) Individual is fully described or identified, 2) Rationale for Positive Behavior Support, 3) Goal/Objective, 4) Functional Assessment, 5) Written PBSP, 6) Plan of Implementation, 7) Program Evaluation, and 8) Professional Integrity. Items in each of these areas were rated on a scale of zero (no evidence the task was performed) to three (Best Practice competence). An aggregate comparison of all PBSPs receiving external peer review during the past six months with those completed during the six months prior to the last site visit is presented below. Area of Competency / Percentage Achieved 9/2010 / Percentage Achieved 3/2011 / Change Competency 1: 78 / 62 / -16 Competency 2: 50 / 57 / 7 Competency 3: 75 / 78 / 3 Competency 4: 52 / 64 / 12 Competency 5: 51 / 52 / 1 Competency 6: 35 / 29 / -6 Competency 7: 33 / 40 / 7 Competency 8: 78 / 84 / 6 Total of all Competencies: 55 / 57 / 2 Based upon this comparison, although training and review practices had been enhanced, behavior assessments and interventions were not substantially or comprehensively improved. The area of greatest improvement, Functional Assessment (Competency 4), remained at less than two thirds of the maximum possible score. Two areas, Describing the Individual (Competency 1) and Plan of Implementation (Competency 6), declined substantially. Difficulties were also noted during the current site visit in regard to the timely revision of PBSPs when approval from the Positive Behavior Support Committee (PBSC) was declined. In the six months prior to the current site visit, 10 PBSPs (6%) were declined	

#	Provision	Assessment of Status	Compliance
		approvals. Of those 10 PBSPs, one was revised and implemented within three weeks, one was revised and implemented within four weeks, one was revised and implemented within five weeks, and seven required in excess of six weeks to be revised and implemented. • A PBSP for Individual #520 was first submitted for review by the PBSC on 10/6/2010. Approval by the PBSC was declined on that date, and was declined again on 12/22/2010. Approval for the PBSB was not gained until 1/5/2011. The PBSP was not implemented until 1/11/2011, over three months after the initial submission date. • A PBSP for Individual #220 was submitted to the PBSC on 12/15/2010. Approval was declined on that date, but contingent approval was granted on 1/12/2011. As of 4/1/2011, final approval had not been obtained and the PBSP had not been implemented. • A PBSP for Individual #725 was declined approval by the PBSC on 11/17/2010. No further submissions were documented and the PBSP had not been implemented as of 4/1/2011. 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, in particular because of delays in responding to the peer review comments by revising the PBSP and because the reviews had yet to produce broad improvements in the PBSPs implemented.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and	Considerable deficits were noted in the collection of behavior data during previous site visits. During the previous site visits, 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 February of 2011, a new data collection system was implemented. This system made use of a standard form for recording data that could accommodate frequency counts, as well as duration, interval and accuracy measures. This new data collection process allowed for much greater flexibility in data collection, but also introduced potentially problematic constraints. Of primary concern was the use of one hour as the standard interval for all data recording. Many PBSC target behaviors could likely be captured using one-hour intervals. The lack of other interval options, however, created a situation in which there was potential for very low and very high frequency behaviors to be miscounted. As a result of these inherent limitations, a very real potential was created for biasing or preventing attempts at evidence-based treatment. In addition to the introduction of new data collection procedures, DSSLC also implemented	Noncompliance

#	Provision	Assessment of Status	Compliance
	that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	the first phase of a process to measure interobserver agreement (IOA) for PBSC data. As the IOA procedure was implemented only a few weeks prior to the site visit, it was not possible to develop a clear measure of whether efforts at collecting IOA data were successful. Nevertheless, the effort to determine the reliability of treatment data was welcomed by the Monitoring Team. Whether based upon the previous or new data collection process, all behavior intervention data were graphed on a monthly basis. In addition, these data graphs were included in a process of monthly review to determine treatment benefit and efficacy. The review process was hindered, however, by a number of circumstances evident in a sample of 18 PBSPs. • For Individual #183, it was indicated that the baseline data for the PBSP were "TBD" (To Be Determined) even after the PBSP was implemented. Without valid and reliable pretreatment data, the ability to determine treatment efficacy was substantially impeded. • For Individual #226, behavior data were reported by month. The nature of the intervention, however, required reporting data by session rather than by month. Furthermore, no data were collected on the opportunity for behavior to be displayed. Due to these factors, it was not possible to use the data for formulating treatment decisions. • For Individual #399, no specific criteria for meeting objectives were included in the PBSP. Without pre-established treatment expectations, it was not possible to determine when or if the intervention was successful. • For Individual #565, instructions for PBSP implementation and data collection were unclear as to the number of trials included in each teaching session. As a result, there was the potential for misinterpretation of treatment data. In addition, pica had increased without a review of the behavior intervention or assessment. In addition to limitations imposed by poorly designed PBSPs, there were instances in which the review process did not provide an adequate oversight in regard to treatment response. • For Individual #45, although the target behavior improved, there was not an indication in the treatment data that the improvement was a result of the treatment offered or the teaching of replacement behaviors. Although the improvement in the target behavior was the goal, understanding what components of treatment, changes in environment, or other events were effective is important in order to be able to maintain those changes, or to intervene effectively when problematic behaviors return. • For Individual #367, target behaviors began increasing in June 2010 and, with the exception of August, remained substantially elevated through the end of 2010.	

#	Provision	Assessment of Status	Compliance
		Despite data that indicated worsening undesired behavior, progress notes provided no information about any specific anticipated benefit from continuing the existing PBSP. Furthermore, no recommendations were made to revise the PBSP or explore the lack of treatment efficacy. In January of 2011, however, when displays of target behaviors dropped to near zero, the recommendation was made to revise the PBSP. Although data suggested the PBSP was ineffective, a revision to the PBSP would have provided greater potential benefit had revisions been introduced in a more timely manner. • For Individual #506, the use of replacement behaviors by the individual dropped to zero in May 2010. The month after, physical aggression increased substantially. Although efforts to improve treatment response through additional training for staff were introduced, physical aggression remained elevated into November 2010. No recommendations for a revision of the PBSP were offered at any point during the eight-month period of higher rates of aggression even though a temporal relationship was demonstrated between the drop in replacement behaviors and the increase in aggression. Due to conditions such as those presented above, it was not evident that evidence-based decisions regarding treatment were routinely formed or even possible. It was noted during the previous site visit that 100% of data graphs reflected only psychotropic drug treatments even though each of the individuals involved also received behavior interventions. This suggested that the primary mode of treatment for individuals living at DSSLC, regardless of whether the target of concern involves mental illness or learned behavior, had been psychotropic medication. This had changed by the current site visit. During the current site visit, it was noted that progress notes included behavior targets as well as psychotropic drug targets for 10 of 18 (56%) individuals sampled. Although the inclusion of behavioral targets for the majority of individuals in the sample is a positive step, there was a substantial limitation noted as well. For six of the 10 individuals (60%) with behavioral targets, there were no data presented for those targets. Therefore, other than the indication that behavior treatment involved more than psychotropic medication, the inclusion of behavioral targets in data graphs did not contribute to the treatment decision process for many individuals. It was evident during the site visit that effort had been made to improve the quality of behavior data, especially in terms of the new data forms that were introduced. Despite these changes, however, it was not evident that changes in data collection had produced meaningful benefits for the clients of the Facility in terms of treatment decisions.	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>K5</td><td>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.</td><td>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 the current cognitive and adaptive abilities of the individual, as well as guidance for skill acquisition training. 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.

Information in the table below reflects that little progress was achieved by DSSLC in integrating adaptive and intellectual testing into the psychological assessment process. Where progress was noted in regard to intellectual testing, the testing was completed by agencies other than DSSLC.

<table>
<tr><th></th><th>Previous Site Visit</th><th>Current Site Visit</th><th>Change</th></tr>
<tr><td>Psychological Assessments contained findings from an intellectual test administered within the previous five years.</td><td>Zero of 11 (0%)</td><td>Two of 18 (11%)</td><td>11%</td></tr>
<tr><td>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.</td><td>Zero of 11 (0%)</td><td>Zero of 18 (0%)</td><td>0%</td></tr>
<tr><td>Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.</td><td>One of 11 (9%)</td><td>Zero of 18 (0%)</td><td>-9%</td></tr>
<tr><td>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.</td><td>Zero of 11 (0%)</td><td>Zero of 18 (0%)</td><td>0%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance

Specific examples of weaknesses in the integration of intellectual and adaptive assessment are presented below.

- For Individual #226, the most recent Intellectual testing was completed in 1989; no adaptive testing was reported.
- For Individual # 537, the intellectual tests, test dates, and test results referenced in the report narrative did not match tabular data regarding intellectual assessment in the report.
- For Individual #687, the most recent intellectual and adaptive assessments were completed in 1987.
- For Individual #774, the most recent intellectual test was completed in 1988. The most recent adaptive assessment was completed in 1985.

The assessment of behavioral function is an essential component of effective behavior change and requires 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 ambiguous 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 or an indication of how ambiguous findings will be resolved. Without additional investigation, ambiguous statements are indicative of an assessment process that has not been completed.

Information in the table below reflects the degree of progress achieved by DSSLC in enhancing the quality of functional assessments.

	Previous Site Visit	Current Site Visit	Change
Functional assessments produced a specific statement or hypothesis of function.	Zero of 13 (0%)	Seven of 18 (32%)	32%
Functional assessments consisted of procedures completed within a year prior to the initiation date of the PBSP.	Six of 13 (47%)	Eight of 18 (44%)	-3%
Functional assessments described formal assessment procedures.	Two of 13 (9%)	Eight of 18 (44%)	35%

#	Provision	Assessment of Status	Compliance

The process or tool utilized both direct and indirect measures.	Five of 13 (38%)	Six of 18 (33%)	-5%

Specific examples of weaknesses in functional assessment are presented below.

- For Individual #45, the assessment report did not reflect a formal functional assessment.
- For Individual #127, the most recent functional assessment was completed over a year prior to the site visit when the individual had lived at DSSLC for less than a month. Functions were identified based upon discussions with the individual's parents regarding behavior displayed prior to admission.
- For Individual #172, a functional assessment process was referenced in the report and a summary of functional assessment findings was provided. The functional assessment protocol, however, was not provided and there was no specific information documented regarding setting events, antecedents, or motivating operations.
- For Individual #537, although setting events and motivating operations were briefly discussed, it was not evident that these factors had been empirically explored. Therefore, it could not be determined that interventions focused on these factors would be successful. Functions were identified in the assessment, primarily based upon the findings of screening instruments. The narrative of the report indicated confusion or lack of clarity regarding the findings of the screenings, but no effort to empirically explore these limitations was presented. Although a replacement behavior was identified in the assessment, it was not clear from the description of the function or the rationale for the proposed intervention that the selected replacement behavior had adequate strength or efficiency to be successful.

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 identify the mental illness being experienced by the individual, as well as determine which undesired behaviors are primarily related to mental illness, which arise primarily due to learning and the environment, and which may reflect a combined origin of mental illness and the environment.

During the previous site visit, DSSLC demonstrated considerable difficulty in incorporating the signs and symptoms of mental illness into the functional assessment process. Although improvement was noted during the current site visit, in most cases functional 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.

#	Provision	Assessment of Status	Compliance

	Previous Site Visit	Current Site Visit	Change
The assessment process included screening for psychopathology, emotional, and behavioral issues.	Five of 13 (39%)	Seven of 18 (39%)	0%
The assessment process included differentiation between learned and biologically based behaviors.	Zero of 13 (0%)	Five of 18 (28%)	28%

Specific examples of weaknesses in the integration of mental illness into the assessment process are presented below.

- For Individual #134, mental illness diagnoses were discussed in the assessment, but were not integrated into the case formulation. Reiss Screen scores were reported as part of the diagnostic presentation, but no scales or measures were described in relation to functional assessment or treatment monitoring.
- For Individual #226, Reiss Screen scores were reported, but there was no integration of the scores into the larger case formulation. The psychiatric case formulation tied anxiety to SIB, but anxiety was not defined or empirically investigated. The proposed intervention did not address anxiety, although operant strategies could effectively be used to decrease anxiety or to teach appropriate escape from anxiety eliciting environments.
- For Individual #774, a Reiss Screen was completed on 12/17/2009. The findings of the Reiss Screen were not discussed in the assessment report although the scores were included. A discussion of medical and psychiatric issues was offered with conclusions regarding the relationship between mental illness and behavior displays. No evidence to support an empirical basis for those conclusions was provided.

There were noted to be examples appropriate integration of mental illness assessment into the functional assessment process.

- For Individual #399, the role of mental illness symptoms as setting events was thoroughly discussed in the case formulation.

In early January 2011, DSSL implemented a revised Psychological Assessment/Functional Assessment protocol. Due to sampling demands and the low number of individuals for whom the new protocol had been used, however, it was not possible to include only the new protocol in the sample.

Based upon observations and record reviews, it was evident that some progress had been achieved. The progress made, however, was not sufficiently comprehensive or pervasive

#	Provision	Assessment of Status	Compliance
		to allow for a determination of compliance in this area.	
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.	Noncompliance
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 reflected 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. For this population, intellectual and adaptive assessment is an essential component of a comprehensive psychological assessment. Record reviews reflected that 100% of individuals residing at DSSLC received an annual psychological evaluation. As indicated in K5, however, only 11% of the completed evaluations included current intellectual testing results and 0% included current adaptive skill assessments.	Noncompliance
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.	DSSLC completed and implemented Counseling Policies and Procedures on 12/01/2010. These policies provide the necessary structure for evidence-based counseling practices. At the time of the site visit, seven individuals living at DSSLC were reported as involved in counseling. Records provided by DSSLC did not, however, include assessments, progress notes or treatment data pertaining to counseling services for these individuals. Therefore, it was not possible to determine progress or compliance in this area.	Noncompliance
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others,	The Facility had a PBSP in place for each individual identified as requiring behavior intervention. Consents and approvals were routinely obtained for PBSPs, restrictive procedures and the use of psychotropic medication. All consents reviewed met basic time frames and procedural requirements. During the previous site visit, numerous weaknesses were noted in both behavior assessment and intervention. As a result, the following conditions were noted. • 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.	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>
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.
Since the previous site visit, DSSLC had engaged in an overhaul of the behavior assessment process, as well as conducted additional training on applied behavior analysis and the development of PBSPs. Based upon observations and a review of records, the efforts of DSSLC appeared to have produced improvement in the PBSPs.
<table>
<tr><th>PBSP Element</th><th>Previous Process</th><th>Revised Process</th><th>Change</th></tr>
<tr><td>Rationale for selection of the proposed intervention.</td><td>50%</td><td>75%</td><td>25%</td></tr>
<tr><td>History of prior intervention strategies and outcomes.</td><td>50%</td><td>88%</td><td>33%</td></tr>
<tr><td>Consideration of medical, psychiatric and healthcare issues.</td><td>40%</td><td>63%</td><td>23%</td></tr>
<tr><td>Operational definitions of target behaviors.</td><td>70%</td><td>63%</td><td>-7%</td></tr>
<tr><td>Operational definitions of replacement behaviors.</td><td>70%</td><td>63%</td><td>-7%</td></tr>
<tr><td>Description of potential function(s) of behavior.</td><td>30%</td><td>75%</td><td>45%</td></tr>
<tr><td>Use of positive reinforcement sufficient for strengthening desired behavior</td><td>10%</td><td>50%</td><td>40%</td></tr>
<tr><td>Strategies addressing setting event and motivating operation issues.</td><td>60%</td><td>75%</td><td>15%</td></tr>
<tr><td>Strategies addressing antecedent issues.</td><td>60%</td><td>75%</td><td>15%</td></tr>
<tr><td>Strategies that include the teaching of desired replacement behaviors.</td><td>10%</td><td>25%</td><td>15%</td></tr>
<tr><td>Strategies to weaken undesired behavior.</td><td>30%</td><td>63%</td><td>33%</td></tr>
<tr><td>Description of data collection procedures.</td><td>20%</td><td>38%</td><td>18%</td></tr>
<tr><td>Baseline or comparison data.</td><td>0%</td><td>13%</td><td>13%</td></tr>
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#	Provision	Assessment of Status	Compliance

Treatment expectations and timeframes written in objective, observable, and measureable terms.	60%	50%	-10%
Clear, simple, precise interventions for responding to the behavior when it occurs.	30%	63%	33%
Plan, or considerations, to reduce intensity of intervention, if applicable.	0%	13%	13%
Signature of individual responsible for developing the PBSP.	90%	100%	10%

As the data reflect, although progress was achieved, the status of PBSPs remained well below standards acceptable within the field of applied behavior analysis. This was particularly evident in relation to the formal teaching of replacement behaviors, the identification and use of powerful reinforcement strategies, the use of true pretreatment or baseline data, the establishment of objective and meaningful treatment expectations, and precise instructions for data collection. Examples of weaknesses are presented below.

- For baselines, the presentation was typically a description of historical behavior rates with no specification of the interventions and environmental conditions in place. A pre-treatment measure is essential in determining whether an intervention is successful. This can certainly consist of data collected from existing conditions. However, there needs to be a clear description of what those conditions have been so the difference from baseline to treatment can be clearly described. Using the data from the previous intervention as baseline is acceptable, so long as there exists a clear delineation between the previous and current interventions. Simply a listing of monthly data for the prior year or two does not constitute a current baseline.
- For Individual #134, the following limitations were noted in the PBSP.
    - A teaching component was presented in the PBSP, but it did not include formal trials or sessions. Rather, staff were to reinforce the behavior when it spontaneously occurred. This process did not ensure that sufficient opportunities for learning to occur would take place. Treatment expectations referred to "trials," but there were no trials described in the PBSP.
    - Data collection instructions were very general; "Fill out the forms."
    - Data from the previous year were referred to as baseline although those data did not reflect a pretreatment condition. There was no description of how staff responded during the previous year differently from what the PBSP required, or whether there were any changes in environmental

#	Provision	Assessment of Status	Compliance
		conditions tied to those data. • For Individual #226, the following limitations were noted in the PBSP. o There was a lack of integration or formulation of the case and treatment options. Current accepted practice requires an integration of environmental sources of behavior and mental illness into both the assessment and intervention process. For this Individual, although general comments referred to both issues, there was no evidence of a cohesive strategy to conform to current accepted practice. It would have been helpful for the PBSP to have included methods of combining behavior and psychiatric interventions into a single, coordinated approach to treatment. ▪ The Psychological Assessment and Functional Assessment included scores from the Reiss Screen for Maladaptive Behavior, but those scores presented or discussed the larger case formulation. ▪ The psychiatric case formulation indicated a relationship existed between anxiety and SIB, but there was no assessment of anxiety or a definition of anxiety in relation to SIB. Without a formal assessment, it was not clear whether the individual experienced an anxiety disorder or displayed behaviors that suggested, for example, agitation, restlessness or frustration. It is essential that factors that potentially contribute to undesired behavior be assessed as thoroughly as possible so that interventions can be focused upon valid targets. ▪ The PBSP did not address the potential relationship between anxiety and SIB, although operant strategies have been demonstrated to effectively decrease anxiety or to increase appropriate escape from anxiety eliciting environments. o Specific data collection instructions were included for replacement behavior training, but for target behaviors the instructions were very general statements to complete the data forms. • For Individual #119, the following limitations were noted in the PBSP. o The PBSP reflected that treatment records were used in the assessment of the target behavior. It was later stated in the PBSP that treatment records were not available. o The PBSP stated that baseline data were unavailable immediately below a graph of behavior data since admission. The PBSP in the same section also stated "data will be reevaluated as it accrues." Baseline data are by definition pre-treatment data. Therefore, ongoing determination of "baseline" data would be inappropriate and detrimental to the treatment process.	

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The Treatment method did not specify a schedule for training, the number of trials per training session, or a procedure for reinforcing desired responses.
The PBSP did not specify treatment expectations and timeframes for achieving those expectations.
Individual #119 had demonstrated potentially dangerous behaviors such as self-injury and statements of suicidal intent. Functions identified included escape, attention and obtaining tangible objects. The Treatment methodology targeted only agitation.

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<tr><td>K10</td><td>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.</td><td>
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 at times of unknown value, the software itself was sophisticated and useful. Most elements required in a data graph were present and the graphs were not overly complex.

During the previous site visit, one weakness of 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, changes were made in behavioral interventions or replacement behaviors, 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. During the current site visit, 53% of data graphs reviewed that were created after January 1 2011 included indicators for changes where appropriate.

Requirements for graphs and the percentage of graphs in compliance from a sample of 18 individuals are presented below.

<table>
<tr><th>Graph Element</th><th>Percentage</th></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>76%</td></tr>
<tr><td>Horizontal axis and label.</td><td>100%</td></tr>
<tr><td>Vertical axis and label.</td><td>53%</td></tr>
<tr><td>Condition change lines.</td><td>29%</td></tr>
<tr><td>Condition labels.</td><td>29%</td></tr>
<tr><td>Data points and path.</td><td>94%</td></tr>
<tr><td>IOA and data integrity.</td><td>0%</td></tr>
<tr><td>Demarcation of changes in medication, health status or other events.</td><td>53%</td></tr>
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One substantial problem noted was that only 75% of graphs reviewed were appropriate to the nature of the data. The PBSPs at DSSLC had increased in sophistication with several
</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		including specific teaching strategies. Such teaching strategies at times used teaching sessions divided into a specific number of trials. Such data are typically presented in the field of applied behavior analysis as the percentage of successful trials per session or day. In many cases, however, the graphs at DSSLC continued to present such training data in the form of total displays per month, a practice that prevented the determination of client progress. An additional problem was the lack of condition change lines. Acceptable practice in applied behavior analysis stipulates that behavior change programs be broken down into discrete conditions or stages. In the simplest form this would involve dividing a behavior change program into a baseline or pretreatment condition followed by a treatment or program implementation condition. More sophisticated behavior change programs can include treatment reversal conditions or conditions for separate treatment methods. The data graphs at DSSLC rarely included indicators for changes in treatment conditions. The primary reason for this was that PBSPs at DSSLC seldom included discrete conditions such as pretreatment baseline conditions. Without the implementation of conditions in PBSPs and the indicators for those conditions on the data graphs, DSSLC imposed considerable impediments to evidence-based treatment. In late February of 2011, DSSLC began a phased implementation of IOA data collection and treatment integrity. This reflected a substantial advance by the Facility. Due to the proximity of the implementation to the site visit, there were not sufficient data to assess the efforts of the Facility. Furthermore, as the implementation was described as gradual, it will likely require several months before implementation is complete. Nevertheless, the effort exhibited by the Behavior Services department in this area is to be commended.	
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.	As noted during previous site visits, observations of and interviews with direct care staff reflected that many staff had difficulties in understanding and/or implementing behavior interventions. As noted in K9, improvement had been made in simplifying the instructions provided to staff regarding behavior interventions. Much of the effort of the Facility, as described in the Facility POI, focused upon limiting the number of pages used for the PBSP instructions. Responses from DSPs differed substantially from residence to residence. Per their reports, some PBSPs used very simple language. Others, however, seemed to respond to the attempts to make the instructions shorter by making the instructions more technical. Readability of written language, however, more typically relates to the number of words in a sentence and the number of syllables and letters in a word. DSSLC might achieve greater success in this area if staff instructions were subject to formal readability measures. At the time of the site visit, DSSLC did not routinely assess the implementation of PBSPs. It	Noncompliance

#	Provision	Assessment of Status	Compliance
		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.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	At the time of the site visit, DSSLC was in the process of developing and implementing a system of competency-based training. As the training had not been fully implemented, it was not possible to assess progress in this area.	Noncompliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	At the time of the site visit, DSSLC employed six staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 90 individuals residing at the Facility and fell far short of the required ratio of one BCBA for every 30 individuals. The Behavior Services department does include a sufficient number of positions to achieve a 1:30 ratio. Should each available position be filled by a BCBA credentialed employee, DSSLC would achieve approximately a 1:26 ratio. In consideration 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.	Noncompliance

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

1. DSSLC should conduct an assessment of current peer review practices. Efforts thus far, while possessing face validity, have not produced broad and comprehensive changes to PBSPs. In addition, for those PBSPs that do not initially receive approval from the Peer Review Committee, the process for revision too often produces excessive delays in the implementation of programs. More efficient and expeditious practices are needed.
2. Additional improvements are needed to enhance the application of evidence-based practices in the formulation of treatment decisions. PBSPs do not include, and data graphs do not reflect, specific and discrete conditions (i.e. baseline, treatment, generalization, etc.) necessary for the identification of meaningful changes in behavior. Data collection forms, although improved, should be expanded to encompass high- and low-frequency behaviors.. Training with the interdisciplinary teams should be implemented to increase their understanding of evidence-based practices and the need for clear and measurable treatment goals. Training should include tools for facilitating the interdisciplinary teams in monitoring response to treatment.
3. Further improvements are needed in the Psychological and Functional Assessments. Individuals living at the Facility should receive regular testing of intellectual, cognitive and adaptive abilities, and have the findings of those tests integrated into the overall psychological assessment. In addition,

functional assessments should incorporate consideration of both mental illness and learned behavior in the development of a coherent intervention strategy.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Denton State Supported Living Center (DSSLC) Plan of Improvement (POI), 03/25/2011 2. DSSLC Medical Care Policy, MED-01, dated 08/17/10 3. Texas Department of Aging and Disability Services, DSSLC Policy: Medical Emergency Response, Policy Number: 044, Date: 7/21/10 4. DSSLC Course Delinquency List; Cardiopulmonary Resuscitation Basic Course and Basic Live Support for Health Care Providers., Printed: 3/7/11 5. DSSLC Fire Drill Meeting Minutes, 12/1/10 and 3/1/11 6. DSSLC Mock Medical Emergency Drill Schedule for all shifts and all areas for 3/2011 7. DSSLC Mock Medical Emergency Drill Report of Completed Drills for Facility, 9/2010 through 2/2011 8. DSSLC Daily Infirmary Crash Cart Checklists, March 2011 9. DSSLC Control Drug Check Sheets and Emergency Equipment Checklists for all Units, March 2011 10. DSSLC Security Equipment Verification Checklists, March 2011 11. DSSLC Death of an Individual who Resides at Denton State School, Policies and Procedures Manual, Medical-07, Date: February 1, 2009 12. DSSLC Death Process, Draft 13. DSSLC Death Review – Recommendation Tracking Log 1/21/11 through 3/23/11 14. DSSLC Mortality Review Update, March 2011 15. Review of Deaths for Individuals #135, #514, #93, #522, #263, #63, #390, #473, #107and #495 16. Clinical records of the following individuals: #129, #175, #785, #307, #191, #133, #275, #63, #89, #35. 17. Medical Provider Quality Assurance Audit Process and forms 18. All completed physician audits from March 2010 to March 2011 (6 completed) 19. Aspiration Triage Data Sheet 20. Diabetic management process, and associated forms, undated 21. Blood Glucose Monitoring process, undated 22. Preventive Care Flow sheet 23. Doctor to Doctor Transfer Progress Record form **People Interviewed:** 1. Stephen Kubala, MD, Medical Director 2. Wes Knox, Data Analyst 3. Sibylle Graviett., Nurse Case Management Supervisor 4. Delia Schilder, RN, Chief Nurse Executive (CNE) 5. Chuck Brookins, Security Officer 6. Deb Salsman, Director of Incident and Risk Management 7. Allana Garrison, RN, Quality Assurance Nurse Supervisor 8. David Anderson, Assistant Security Officer 9. Sherri Courtney, RN, Nursing Operations Officer (NOO)

	10. Laura Stoffels, RN, Nurse Investigator 11. Valerie Kipfer, RN, State Office Nursing Coordinator **Meetings Attended/Observations:** None
	Facility Self-Assessment: Provision L1. The Facility informed the Monitoring Team that it has determined that they were not compliant with Provision L.1, of the Settlement Agreement. The following activities were reported by the Facility to the Monitoring Team for Provision L.1, of the Settlement Agreement. The Facility implemented a record verification checklist to ensure that appropriate documents were sent to the hospital, at the time of admitting an individual for acute medical service. The Monitoring Team reviewed the document at the time of interviewing the Facility's Medical Director, and noted its potential benefit. The Facility developed and implemented an oxygen protocol, which was intended on providing nursing staff with oxygen saturation parameters for the administration of oxygen. The Monitoring Team complements the Facility on this effort, however, the Team had raised concerns over the comprehensiveness of the protocol, and specific oxygen saturation parameters outlined in the protrocol. The Facility has consulted with a cardiovascular specialist to help providers better understand the appropriate uses of echocardiograms. The Monitoring Team recognizes the benefit of this service. To enhance outcomes secondary to hospitalizations, the Facility continued to liaison with the local hospital and hospitalist. The Monitoring Team complements the Facility on this out-reach effort. Enhancing relationship with the local hospital will result in quality outcomes for Individuals served, who require acute hospital admission. The Facility developed a Transfer Physicians Order protocol. The Monitoring Team reviewed the protocol and associated order forms, and concurs with its application at the Facility. The Facility provided additional training for clinicians at the Facility so that they better understood the need to complete the Preventative Care Flow Sheet accurately. Following review of medical records, the Monitoring Team suggests that additional training and close monitoring for completeness and accuracy of the flow sheet. The Facility has reviewed the Annual Physical Assessment Form to ensure that the template included all components of the HCG. At the Time of this review, the Monitoring Team did not review the new assessment form, and will do so on subsequent review.

	The Facility reported that active problem lists would be utilized on a separate gold card with new active problems identified as they occur and note when the active problems are resolved. The Monitoring Team did not find this new process implemented, following its review of clinical records. Provision L2: The Facility reported to the Monitoring Team that they were in substantial compliance with Provision L.2, of the Settlement Agreement. The Facility reported that they developed a process where there is periodic psychiatrist meetings with the neurologist to review cases that require neurological intervention. The Facility reported to the Monitoring Team that a Hospitalist had been added to the list of participants for death reviews. Following review of recent death reviews, the Monitoring Team noted that the Facility had challenges to consistently, and timely engage the external physician in the review process. The Monitoring Team was informed that the Facility has external medical providers to conduct quarterly QA audits; external medical providers conducted quarterly provider QA audits. Five percent of each provider's charts were audited at initial audit.. Importantly, the Monitoring Team notes that the audit form used for these reviews consists of a checklist of required activities and provides little review of other aspects of quality of practice. The State Office continues to work to develop a process for data collection and trends analysis. The Monitoring Team does not concur with the Facility's assessment and determined that the Facility is not in substantial compliance with Provision L.2. Provision L3: The Monitoring Team was informed by the Facility that it was not in compliance with Provision L.3, of the Settlement Agreement. The Facility reports that physicians conduct quarterly medical reviews of their practice. This review is an audit of physician activities and is not specific to clinical outcomes. The Monitoring Team recommended to the Facility that it develop a meaningful QA process to assess clinical outcomes. The Monitoring Team was informed that Dilantin and phenobarbital levels were regularly reported to the medical director and primary care provider for tracking. The Monitoring Team understands the rationale for this activity; however, it strongly recommended that the process be enhanced to include prompt notification of all laboratory values that are determined to fall under the category of a "panic value". The Medical Director completed monthly clinic reviews. This is a meaningful process where by the medical director attends various clinical and evaluations at the Facility and offers recommendations to the treating clinician. This process was noted by the Monitoring Team to be of considerable effort and will improve clinical outcomes.

	Provision L4: The Facility had determined that they remained non-compliant with Provision L.4, of the Settlement Agreement. Working towards compliance, the Facility reports that they continue to work with the State Office on developing clinical pathways for prevention and treatment of aspiration pneumonia.
	Summary of Monitor's Assessment: The Monitoring Team determined that the Facility does not yet comply with any provision of this section but has initiated many actions and improvements to move toward compliance. Since the last review for the Settlement Agreement, under the leadership of Dr. Kubala, the Facility's Medical Department has made significant systems improvements, that if further developed and implemented, will help lead the Facility to substantial compliance of Section L of the Settlement Agreement. The Facility has seven full time practicing physicians and two nurse practitioners, and a fulltime Medical Director. Importantly, the Facility is enhancing its physician specialty clinics and will have robust on-site consultation for podiatry, pulmonology, gastroenterology, physiatry, and will be enhancing it's on-site scoliosis clinic with more frequent visits by specialists in orthopedics. To enhance the ability to efficiently obtain necessary x-rays and echocardiograms, the Facility contracts with a mobile radiology firm that enables remote access to radiologic imagines and reports. The Facility has enhanced its liaison with the local hospitals and also contracted with a hospitalist who will collaborate with the Facility Physicians on cases admitted for hospitalization. The Facility also developed a new hospital discharge summary form, which is completed by physicians and nursing staff. This form will ensure that important hospital information is better communicated upon hospital discharges. Many internal processes have been improved upon. For example, the Annual Assessment form is currently being updated to better reflect clinical practice. A new "transfer physician order" form has been developed and implemented. A "Call a Nurse For" poster was created and is posted throughout the living area, to advise non-clinical staff on important issues that must be well communicated to clinical staff. The PNMT committee better addresses significant health concerns of individuals served by the Facility. The Facility is working with the Scottish Rite Hospital and arranging for webinar in-services on important and common neuromuscular and orthopedic conditions, such as cerebral palsy, muscular dystrophy, spina bifida, congenital scoliosis, club foot, and degenerative spine disease. Medical Services has been working collaboratively with nursing, psychology and dental services to enhance the care of Individuals with a history of, and predisposition of aspiration pneumonia. Benefit from this collaborative action will be assessed on future reviews. The Facility continues to work collaboratively in developing "clinical pathways" as was the core group in developing the pathway for aspiration pneumonia, which is under final review by DADS central office. The Facility has dedicated a full time physician staff member to conduct medical chart audits. Additionally,

	the Facility has significantly enhanced its ability to conduct mortality reviews. Significant issues continue with the management of chronic and acute medical conditions. Failure to follow-up on clinical conditions, consultation recommendations and abnormal diagnostics, was evident during the Monitoring Teams review for Provision L. The clinical management of orthopedic conditions, diabetes, and especially pulmonary conditions must be immediately enhanced by the Facility. Based on the Monitoring Team's review of Provision L.1, of the Settlement Agreement, the Review Team agrees with the Facility's self assessment and has determined that the Facility remains non-compliant with the Provision. The Facility must enhance its ability to manage and follow up on acute and chronic conditions, significantly enhance its ability to address pulmonary conditions, orthopedic and diabetes, enable more comprehensive and complete documentation practice to include all known diagnosis, along with a plan and follow-up schedule for each condition. Medical and nursing issues must better be reflected at the PSTs and well documented in PSPs and addendums to PSPs. Following its review for compliance with Provision L.2, the Monitoring Team does not concur with the Facility and has determined that the Facility is not in substantial compliance with the Provision. The Facility must enhance its process of providing medical audits as delineated in the report. External audits have occurred quarterly, and internal audits are continuing. These audits focus on documentation and other required activities and are valuable but need to be supplemented by review of quality of decision-making, planning, and clinical outcomes. Due to lack of the Facility's development of a meaningful quality assurance process, the Monitoring Team concludes that the Facility is not in compliance with Provision L.3, of the Settlement Agreement. Per review, findings and determination for Provision L.1, and the Facility's continued, uncompleted work towards developing clinical pathways and enhancing generally accepted professional standard of care, the Monitoring Team determines that the Facility is not in substantial compliance with Provision L.4, of the Settlement Agreement.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The	The Facility informed the Monitoring Team that it has determined that they were not compliant with Provision L.1, of the Settlement Agreement. The Monitoring Team concurs that the Facility is not substantially compliant with Provision L.1. To assess compliance of Provision L.1 of the Settlement Agreements, the Monitoring Team conducted a meeting with the Facility's Medical Director, Dr. Stephen Kubala, and reviewed the active clinical records of Individuals #272, #618, #175, #578, #785, #191, #133, #63, and #35. The Monitoring Team also requested a copy of the Facility's Doctor to Doctor Transfer Progress Record, Oxygen protocol, copy of preventive care flow sheet	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	and related policy, transfer records on most recent 20 hospital transfers. The Monitoring Team reviewed the "Doctor to Doctor Transfer Progress Record" form, and found the documents to be comprehensive and clinically relevant. Full implementation, over time, should enhance clinical outcomes. A specific policy for the "Doctor to Doctor Transfer Progress Record" is currently being developed by the Facility. The Facility's "oxygen protocol" was reviewed. This protocol was developed to help nursing staff triage Individuals with acute respiratory exacerbation. Although the Monitoring Team compliments the Facility for this initiative, the protocol should be more inclusive. A comprehensive protocol to address the various needs of oxygen at the Facility would be more effective. The protocol should include the various types of oxygen delivery systems at the Facility and their appropriate use, and maintenance. Types of oxygen delivery, such as nasal cannula, mask, and re-breather should be addressed by the protocol. Because of behavioral challenges and anatomic anomalies, not all individuals at the Facility can benefit by nasal cannula, and is some cases a mask may not be beneficial. Most important, physicians and nurses must be acutely aware of the individual's medical condition. Many individuals with intellectual and co-morbid physical conditions have moderate to severe pulmonary conditions, such as restrictive lung disease and chronic obstructive pulmonary condition. Depending on the underlying pulmonary condition, high levels of oxygen may be contraindicated. Most important, physician and nursing staff must be well enabled, through competency based training and continuing medical education, on triaging respiratory emergencies. Clinical staff must be made aware of the fact that an abrupt change in oxygen saturation usually indicates a serious and potentially life threatening medical condition requiring assertive management. Critical to the triage process is the ability to and understanding of notifying Emergency Medical Services, sooner, rather then later. The Monitoring Team reviewed the Facility's "Preventive Care Flow Sheet." An associated policy was not provided. Of note, the flow sheet reports a blood pressure of <140/90 to be normal. Based on current practice a blood pressure of <120/80 is considered normal, while 120-139/80-89 is considered "pre-hypertension" and requires assessment. Considering routine screening for colon, prostate and cervical cancer, the Facility must address the risk and benefits of screening through the Team Process. In some, limited, cases the risk of the screening procedures may outweigh the benefits, and the legally responsible person must be aware of such issues. Specific to Diabetes, the flow sheet states that an A1C is to be done annually or at the discretion of the physician, foot exam to be completed annually, and blood pressure to be maintained less then 130/80. Individuals who receive insulin and all individuals whose diabetes in not under perfect control, require more frequent assessments, especially with	

#	Provision	Assessment of Status	Compliance
		A1C levels and foot exam. Other issues that must be routinely assessed include autonomic and peripheral neuropathy. Also, new data questions the rationale for maintaining blood pressure less then 130/80 for a person with diabetes. It would be advantageous to review routine diabetic management issues with an endocrinologist, after reviewing the current literature. Regarding cervical spine x-rays for persons with Down Syndrome, the flow sheet requires an x-ray and baseline and every ten years. The issue of cervical spine disease in individuals with Down Syndrome, as well as many other individuals with intellectual disabilities, is significant and may lead to permanent disability and death. For this reason, it is advisable to review this screening practice, in collaboration with an expert in orthopedic conditions associated with disabilities; a graduated, and comprehensive screening process for all individuals at the Facility would be advantageous. Specific to immunization, the Facility should carefully review the CDC recommendations for adult immunization and address all recommended vaccines, including measles, mumps, rubella and meningococcal. Specific to pneumococcal vaccine, the Facility should review the definition of "at risk" individuals and if appropriate, consider individuals who reside at the Facility as at risk. Importantly, the Facility should review the CDC's recommendation on verification of persons who are reported to have been immunized in the past. The CDC has specific documentation requirements that must be satisfied, before assuming that one is immune and does not require vaccination. Additional findings and recommendations regarding the Facilities immunization practice can be found in Provision M.1, of this report. Although the mortality rate at the Facility had declined, the Facility continued to experience a mortality rate that indicates a need for continued attention to care (see Provision L.2). Following review of mortality data and records, the prevailing condition leading to death at the Facility is pulmonary, which is generally secondary to aspiration and pneumonia. It is evident by review that risk stratification, monitoring, treating underlying conditions, aspiration precautions and triaging of emergencies, must be enhanced at the Facility. Competency based training for physicians, nursing, and direct care staff must be developed and routinely provided. Facility leadership should assertively review staff performance and develop outcome and performance measures to address aspiration, choking, pneumonia, and asphyxia. The Monitoring Team reviewed an undated draft policy, "Diabetic Management". The policy provides excellent information for nursing and direct care staff on providing services and managing those with diabetes at the Facility. The Facility did not have a procedure that physicians are required to adhere to; it did have the Health Care Guidelines for physician use while the state is in the process of developing a clinical pathway related to diabetes management. Diabetes management continues to need	

#	Provision	Assessment of Status	Compliance
		improvement at the Facility; a clinical pathway should provide guidance to improve treatment. It is essential that physician staff employ current standard of care practices at the Facility. Review of active clinical records indicated that enhanced follow-up and assessment is required for people with diabetes. Individuals with diabetes who have unstable blood sugars require physician evaluation at least every three months. Increased frequency of A1C levels, physical assessment for foot ulcers, and evaluation of autonomic and peripheral neuropathy, and renal impairment must be enhanced. Review of active clinical records of Individuals #129, #175, #785, #307, #191, #133, #275, #63, #89, and #35 identified some improvement with regards to documentation practice; however, physicians were not consistent in employing the SOAP format. Of significance, follow-up to acute and chronic issues continues to be an issue. It is evident by review that physicians were not assertively and consistently following up on acute conditions, following an initial assessment. It is essential that all acute clinical issues are followed up, timely, until resolution by the physician. The following cases demonstrate issues related to clinical management and follow-up: Individual #272: Clinician note dated 1/27/11, which was not in SOAP format, documented result of a chest x-ray, which demonstrated mild pulmonary vascular congestion. The physician documented "will do daily weights and repeat chest x-ray in 2 weeks." No physical exam was carried out for this important issue. There was no follow-up note and no repeat chest x-ray noted in the record. A cervical spine x-ray was obtained on 12/7/11 that demonstrated multilevel disc space narrowing, and degenerative osteophytes. A skull x-ray was obtained on 11/13/09 secondary to a fall. The x-ray reported significant issues of C2 and C3 of the cervical spine, that was suggestive of infection or metastasis. An x-ray of the cervical spine dated 12/7/07 demonstrated spondylosis. OT/PT commented at the PST on January 25, 2011 that the individual "is at low risk for falls because he walks slowly with wide base of support." The individual was observed by the Monitoring Team to have an abnormal gait. Despite this serious pathology noted on multiple x-rays and a continued history of serious falls, an assertive evaluation for spine disease had not been undertaken. X-ray of the chest, dated 1/26/11, demonstrated degenerative changes of both shoulders. This issue was not delineated on the problem list, nor was it considered on the Individuals restraint protocol. The individual is known to have Barretts esophagus, which is a serious condition that may manifest as a malignancy. Follow-up was not documented in the clinical record. The individual is known to have sleep apnea. Sleep apnea may manifest in serious psychiatric and medical conditions and can be fatal. Assertive management for sleep	

#	Provision	Assessment of Status	Compliance
		apnea was not documented in the clinical record. The individual was noted to have a nasal lesion and was referred to an ENT on 10/14/10. The individual was not seen by the ENT and was not followed by ENT until 3/10/11 and was diagnosed with nasal septum deviation, requiring septoplasty. Clinician note of 3/11/11 was written for review of the ENT consult. The Facility Physician simply re-wrote the recommendation of the ENT – "rec if symptomatic, septoplasty will help nasal discharge." No further assessment or monitoring was noted, per review of the recommendation. Following review of the PSP and addendums to the PSP, the Monitoring team noted failure to fully represent the Individuals health care issues and needs. Individual #618: This individual was observed by the Monitoring Team during a final discharge planning meeting. The following issues were not addressed by the clinician, nor was the receiving agency aware of these conditions. This issue clearly suggests the need for significant improvement with discharge planning. • Chest x-ray dated 10/14/05 demonstrated osteophytes. Physical management assessment commented on possible need for orthopedic follow-up. No documentation was noted by physician and this condition was not on the active problem list or nursing care plan. • Chronic Gastritis diagnosed by EGD on 2009. There was no follow-up plan was noted in the record. • Physical management assessment of 2007 commented on the diagnoses of megacolon, osteophytes, diverticulosis, and Barretts esophagitis. These conditions are all very serious. Barretts esophagitis must be followed closely because of possible progression to cancer of the esophagus. Megacolon can result in serious constipation, obstruction and perforation of the colon, hence, must be routinely followed. Osteophytes of the spine suggest a degenerative condition and may manifest severe pain and progress to paralysis. • EKGs in 2009 and 2010 demonstrated left ventricular hypertrophy (cardiac enlargement), and possible ischemia.. The clinician must evaluate and rule out coronary disease and cardiac hypertrophy. • There were no special precautions noted for GERD. • The individual had a diagnosis of chronic constipation, history of megacolon and	

#	Provision	Assessment of Status	Compliance
		known internal hemorrhoids, which was diagnosed on multiple colonoscopies.., The individual was not on stool softeners, and no special monitoring or care plan was noted for this condition. • The individual had colon polyps that were removed by colonoscopy. There was no comment on follow-up plan for repeat colonoscopy. • Pica has been diagnosed in this person. Pica is generally not a curable condition. Life long safeguards must be provided. The transfer plan was not assertive enough to support the individual's Pica diagnosis.. • The individual was on Zyprexa, which requires metabolic screening. The only monitoring issue mentioned was that of regular accuchecks. There are well known and expected parameters necessary to monitor for this medication. • The individual had behavior characteristics suggestive of Autism, (manifested stereotypical movement, favors routines, avoids noises and direct contact with people). Autism was not on the diagnosis, and no plan was provided to assess for or rule out autism. The psychologist at the discharge planning meeting concurred when the Monitoring Team mentioned the possibility of autism and indicated the team had intended to but forgotten to add that diagnosis. This diagnosis could lead to supports and treatment specific to diagnosis and increase the likelihood of a successful move. • Staff commented on nocturia; however, there was no formal medical evaluation for this condition. The Monitoring Team assessed the Facility's ability to respond to medical emergencies: The CNE and NOO explained nursing's role and responsibilities pertaining to the Mock Medical Emergency Drills and Code Blue events, which included: • The nursing staff and security staff completed daily checks of Emergency Medical Equipment. The Automatic External Defibrillators (AEDs) were checked every shift by the Unit Charge Nurses and documented on the RN 24Hour Reports. • Since the last tour a Quality Assurance Nurse had begun conducting the Mock Medical Emergency Drills. • One hundred percent of the nursing staff were up to date in Cardiopulmonary Resuscitation (CPR) training.	

#	Provision	Assessment of Status	Compliance
		The Facility had made numerous improvements in their Emergency Response system since the last tour. This was validated through interview and discussion with Chuck Brookins, Security Officer, Deb Salsman, Director of Incident and Risk Management, Allana Garrison, RN, Quality Assurance Nurse Supervisor, David Anderson, Assistant Security Officer, Delia Schilder, RN, Chief Nurse Executive (CNE), and Sherri Courtney, RN, Nursing Operations Officer (NOO) as well as review of on and off site documents. Improvements included: A formalized schedule was developed for conducting Mock Medical Emergency Drills according to the Emergency Response Policy as well as a system for tracking and reporting completed drills. The Facility began reporting and discussing Mock Medical Emergency Drills in the quarterly Fire Drill Committee beginning in December 2010. The Safety Director stated that plans were underway to change the Fire Drill Committee to a Drill Committee that would include review of all forms of drills conducted at the Facility. He stated that the CNE would serve as a member on the Drill Committee. He also stated that the Quality Assurance Nurse, who was a certified CPR instructor, was conducting Mock Medical Emergency Drills on all shifts according to the drill schedule. In April 2011 a Respiratory Therapist will be added to assist with the drills. A template for tracking and trending the outcome of the drills had been developed but had yet to be implemented. The Facility needs to ensure that Mock Medical Emergency Drill data are reviewed at least monthly and trends analyzed quarterly. Documentation of trends and follow-up on systemic corrections of identified issues must be maintained. As part of the Unusual Incident Review, when Code Blue events occurred the Facility immediately conducted a Critical Incident Review (CIR) to critique the response to the event. The Facility should consider including CIR information in the Drill Committee discussion with a focus on the timeliness and appropriateness of the staffs' emergency response to Code Blue events. Review of the completed Mock Medical Emergency Drill Sheets for the past six months revealed, as was found in past reviews, physicians did not participate in the drills and the nursing staff did not always participate in the drills. In order to have satisfactorily completed drills, the medical and nursing staff need to consistently participate in drills to ensure preparedness in responding to medical emergencies. Review of the Security Equipment Verification Checklists for March 2011 indicated equipment was consistently checked daily on each shift. Review of the Infirmary Crash Cart Checklist for March 2011 indicated equipment was consistently checked daily on each shift. Review of Cedar Falls and Houston Park Emergency Bag Checklists indicated equipment was consistently checked daily on each shift. Review of the DSSLC Course Delinquency List, printed 3/7/11, indicated that across all	

#	Provision	Assessment of Status	Compliance
		disciplines, 13 staff were delinquent in CPR certifications and one nurse was delinquent in Basic Life Support for Health Care Providers (CPR/AED). The Facility's managers and supervisors need to ensure that all staff remain current in CPR and Basic Life Support for Health Care Providers (CPR/AED) certifications. Following its review, the Monitoring Team has determined that further enhancements in the area clinical management must continue to be enhanced, before substantial compliance can be considered. The Facility had made significant system improvements, as delineated above (Monitor Summary), that if continued, will help bring the Facility into compliance with Provision L.1, of the Settlement Agreement.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	To assess compliance of Provision L.2, of the Settlement Agreement, the Monitoring Team conducted a meeting with the Facility's Medical Director, Dr. Kubala, reviewed mortality review process, reviewed draft policies and procedures for Medical Record Audits, and reviewed Medical Provider Quality Assurance Audits. The Facility had improved on developing a medical review system. At the time of the review, the Facility reported that an external audit was conducted in September, 2010 by Dr. Shiply,. Two external audits had been performed by DADS medical staff from State Office and other SSLCs in August, 2010 and February, 2011. In addition, internal audits, conducted by alternate physicians at the Facility, had continued through February of 2011; each of these reviewed records for 5% of the Facility population. The Monitoring Team was provided with ten completed internal audits for review. The audits consisted of employing the Medical Record Audit form, which is a checklist of 28 items. A formalized policy and/or procedure had yet to be developed for the internal audits; however, there was a draft procedure in place that delineates roles and responsibilities for conducting the audits. The Facility did not have a mechanism in place to track trends longitudinally, nor a process to ensure appropriate remediation. Importantly, the checklist captures important documentation issues, but reflects little on actual provision of standard of care practice. These are valuable but need to be supplemented by review of quality of decision-making, planning, and clinical outcomes. A couple of observations about the process might assist in ensuring the process meets the needs of the Facility, and complies with the Settlement Agreement. Many of the questions focused on administrative issues, i.e. were progress notes signed, dated, and timed. It would be helpful to review specific problems to determine if treatment was appropriate. This would allow feedback to be provided regarding treatment of specific conditions, such as treatment of pneumonia, UTIs, or GERD, etc. More specifically, Questions #17 and #26 were all encompassing and extremely broad. It would be helpful to have a #26.a, and have the reviewer go through the record to track a specific diagnosis (e.g., GERD, aspiration pneumonia, constipation). It also would help standardize the system, if one diagnosis was the focus for the review across the entire state, during the quarterly	Noncompliance

#	Provision	Assessment of Status	Compliance
		review. It was difficult to determine the depth of the review when the answer to #17 and #26 was simply "yes." Such reviews must include a robust method of assessing clinical practice. Subsequent reviews by the Monitoring Team will evaluate efficacy of the Medical Record Audits and review the Facility's trends analysis, process for remediation, and will review approved and operational policies and procedures. Compliance will require corroborating record audit findings and recommendations with review of the clinical record. The Monitoring Team conducted a comprehensive review of the Facility's Mortality Review Process: Since the last Tour DSSLC had made improvements in their Death Review Process. Recently the Nurse Investigator assumed the responsibility for overseeing the Death Review Process. The procedure for the Death Process was in draft. The Facility had developed a comprehensive database tracking for the Death Review process through to resolution according to the Death of an Individual who Resides at Denton State School, Policies and Procedures. The Administrative Death Review – Recommendation Tracking Log included the following items: • Date of Death • Individual's Name • Home • Unusual Incident Number, as applicable • Recommendation(s) • Person Responsible • Due Date • Completion Date The Facility provided the Monitoring Team with a Mortality Review Update, March 2011. The update provided the following information: • The average age of Denton SSLC's population as of 1/1/10 was 49.8 years old. As of 1/1/11 the average age was 50.54 years old. • The average age of individuals at the time of their death was 55 years old based upon data since 2007. The average age of death for those dying since January 2010 was 59.71 years of age. • The youngest individual at the time of their death was 25 years old. • The oldest individual at the time of their death was 88 years old. • In 2010 there were 23 deaths at Denton SSLC and a starting census of 571. Adjusting for the population, this gave Denton SSLC a mortality rate of 40.2 per 1,000 in 2010. The Monitoring Team Report, dated November 19, 2010, noted a death rate of 50.6 based on an average census of 573 individuals (October 2009 – October 2010). Since the last compliance visit there had been six deaths. In 2011 there had been two deaths as of March 23, 2011. The mortality rate at	

#	Provision	Assessment of Status	Compliance
		DSSLC continued to decline. • The previous review of mortality, dated January 20, 2011 (with some updated data) noted: o In review of the Death Log Spreadsheet maintained by Incident Management for deaths of individuals since January 2008 it was noted: ▪ There were a total of 78 deaths in this time period. Of the 78 deaths: • 16 had life support withdrawn • 46 had a Do Not Resuscitate (DNR) orders • 13 were on Hospice • 12 had lengthy hospital stays ▪ Weight at the time of Death: This data source included weigh data and appropriate weight range data on 68 of the 78 individuals who died during this time period. Of the 68, according to the information provided by the Facility: • 12 were below their Average Weight Range (AWR) • 26 were below their AWR (sic) • 30 were above their AWR The table below describes the causes of death and the number of deaths for each cause of death. This information will serve as a benchmark for future compliance reviews.	

Deaths May 2009 – March 20011 Causes	**Number of Deaths**
507.00 Pneumonitis due to Inhalation of Food or Vomitus	11
486.00 Pneumonia, Organism Unspecific	8
995.91 Sepsis	7
427.50 Cardiac Arrest	5
518.81 Acute Respiratory Failure	4
Unknown	3
117.90 Other and Unspecified Mycoses	1
410.90 Acute Myocardial Infarction, Unspecified Site, Episode of care Unspecified	1
414.00 Coronary Atherosclerosis of Unspecified Type of Vessel, Native or Graft	1
428.00 Congestive Heart Failure, Unspecified	1
557.00 Acute Vascular Insufficiency of intestine	1
586.00 Renal Failure	1

#	Provision	Assessment of Status	Compliance

785.51 Cardiogenic Shock	1
798.10 Instantaneous Death	1
799.01 Asphyxia	1
799.10 Respiratory Arrest	1

The following recommendations were made by the Clinical and Administrative Review Committees' from previous review mortality reviews. The recommendations, which represented critical thinking related to the findings from the previous Clinical and Administrative Death Committee Reviews included:

- Continue efforts of the combined Physical and Nutritional Management Committee related to pneumonia and aspiration pneumonia. Implemented a combined committee October 2010. Status: Root Cause Analysis completed, Physical and Nutritional Management Teams implemented and efforts are ongoing.
- Continue implementation of statewide initiatives to reduce aspiration pneumonia. Status: All Personal Support Teams will have met to review and revise At Risk designations and plans for people receiving Enteral Nutrition and/or who have experienced Aspiration Pneumonia since May 2009 by March 31, 2011. New process is being put into place as Personal Support Plans occur.
- Provide visual cues at home related to reporting of signs and symptoms. [of aspiration pneumonia]. Status: In place. Information obtained from Massachusetts. Posters created and posted in homes. Staff assigned to inform and remind. Need to incorporate into new plan for Competency Based Training.
- Develop a sub group for the Quality Assurance/Quality Improvement committee to put into place better options for people related to purchases of food items to reduce issues with obesity. These may include elimination of vending machines, healthier options stocked in vending machines, non-food options at Wooden Nickel, expansion of training, and more. Status: Workgroup determined at January 20, 2011 Quality Improvement meeting. Some healthier options have been implemented and additional recommendations will be presented to Quality Assurance/ Quality Improvement Council.
- Developed increased end-of-life initiatives in light of increasing age of persons served by Denton SSLC. Status: Group met in February 2011, is currently developing increased training for staff as well as reviewing and making recommendations for revision to the Ethics Committee policy. Next meeting is scheduled for first week in April 2011.

#	Provision	Assessment of Status	Compliance
		The Monitoring Team reviewed the Administrative and Clinical Death Reviews and the accompanying recommendations for eight Individuals #135, #514, #93, #522, #263, #63, #390, and #473 with the CNE, NOO, Nurse Investigator, and State Office Nursing Coordinator. The purpose of the review was to monitor the Facility for compliance with their death review policy and the quality and appropriateness of recommendations generated by the Administrative and Clinical Death Review Committees. Review of the Clinical Death Review Committees for compliance with the Death Review Policy included the following findings: • The physicians' Death Review Summary was completed within five days in eight of eight (100%) of the deaths. • The Quality Assurance Investigation was completed within five days in eight of eight (100%) of the deaths. • The Clinical Death Review Committee met within 14 days in seven of eight (88%) of the deaths. • The Medical Director was present at eight of the eight (100%) of the Clinical Death Reviews. • The Nursing Director was present at eight of the eight (100%) of the Clinical Death Reviews. • The Attending Physician was present at seven of the eight (88%) of the Clinical Death Reviews. • The Nursing Supervisor was present at eight of the eight (100%) of the Clinical Death Reviews. • An outside physician was present at three of the eight (38%) of the Clinical Death Reviews. • The Clinical Death Review Committee Reports were completed within 21 days after the death in eight of the eight deaths (100%). • There was no documentation regarding efforts to obtain outside physicians for Clinical Death Reviews. Review of the Administrative Death Review Committees for compliance with the Death Review Policy included the following findings: • The Physicians' Death Summaries were submitted to the Administrative Death Review Committee within seven days for six of the eight (75%) of the deaths. • The Administrative Death Review Committees met within 30 days of receipt of the Clinical Death Review Committee Reports in eight of the eight (100%) of the deaths. • The Facility Director was present at eight of the eight (100%) of the Administrative Death Reviews. • The Medical Director was present at eight of the eight (100%) of the	

#	Provision	Assessment of Status	Compliance
		Administrative Death Reviews. • The Nursing Director was present at eight of the eight (100%) of the Administrative Death Reviews. • The Public Representative was at eight of the eight (100%) of the Administrative Death Reviews. • The Qualified Mental Retardation Professional Reports were submitted the Administrative Death Review Committee within seven days for one of the eight (13%) of the deaths. • There was no documentation validating that summaries of actions from the recommendations were submitted to the Department of Aging and Disability (DADS) 14 days after the Administrative Death Review Committee Meetings. • There was no documentation validating that the physicians' death summaries were sent to DADS 14 days after the Administrative Death Review Committee Meetings. • There was no documentation validating that Unusual Incident Reports, if applicable, were sent to DADS • There were no autopsies performed on the individuals who died. The Facility needs to ensure that efforts are made to have an outside physician review clinical records of the decedents' and attend the Clinical Death Review Committee Meetings. The Facility needs to ensure that all relevant information required by policy is submitted to DADS within the specified timeline and that there is documentation of the submission. The Monitoring Team reviewed recommendations from the Clinical and Administrative Death Review Committees with the CNE, NOO, Nurse Investigator, and State Office Nursing Coordinator. The Monitoring Team agreed with the nursing recommendations that grew out of the Clinical and Administrative Death Review Committees. It was positive that the Facility conducts an immediate Critical Incident Team Meeting after an individual dies and for other serious events. Review of Individual #107's Critical Incident Report indicated that it was conducted on 3/28/11 at 1:10 a.m. after his death at 11:53 p.m. The entire team was in attendance and discussed events and issues leading up to and surrounding Individual #107's death. The Monitoring Team will review Individual #107's Clinical and Administrative Death Review Committee Reports at the next review. On 3/30/11 the Monitoring Team attended the Administrative Death Review Committee Meeting regarding the death of Individual #495. The committee meeting was conducted within 30 days of the death. All required committee members were in attendance of the meeting. The committee was chaired by the Facility Director. The Clinical Death Review	

#	Provision	Assessment of Status	Compliance
		Committee's Report was thoroughly reviewed and discussed regarding circumstance surrounding Individual #495's death and the care, services and supports he received. Recommendations were formulated. The Monitoring Team will review Individual #495's Clinical and Administrative Death Review Committee Reports at the next review. Following its review for compliance with Provision L.2, the Monitoring Team does not concur with the Facility and has determined that the Facility is not in substantial compliance with the Provision. The Facility must enhance its process of providing "medical audits", as delineated in the report. The Facility must also continue to enhance its mortality review process by improving documentation of the reviews, ensure timely reviews by external physicians and developing a mechanism to ensure that recommendations are effective long-term.	
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 Monitoring Team conducted a meeting with the Facility's Medical Director, Dr. Kubala, and requested policies, procedures, forms and related data specific for the Facility's quality improvement process. Although the Facility had reviewed the incident rate of decubitus ulcers and mortality secondary to aspiration pneumonia, the Facility did not have a medical quality improvement process in place, at the time of this review. Data specific to clinical outcomes were not collected, nor was trend analysis completed. Outcome data, such as diagnostic results that indicated appropriate clinic treatment (e.g., improved or normal A1C levels in people with diabetes, improved bone density measurements following treatment for low bone density), as well as other variables, including reduction of death from aspiration and sepsis, and reduction in certain infections, reduction in fracture rate in those with known low bone density comparing those treated for low bone density and not, are some important variables that should be collected Compliance with Provision L.3, will require a system that will capture medical indicators, such as specific conditions, hospitalizations, EMS calls, deaths, and importantly, data points, such as laboratory and other diagnostic results, that can demonstrate efficacy of clinical practice at the Facility. Data must be maintained longitudinally and must be used to conduct trend analysis regularly, identify areas for attention and improvement, and determine effectiveness of initiatives taken to improve health status and services.	Noncompliance
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that	Dr. Kubala informed the Monitoring Team that the Facility remains out of compliance with Provision L.4. and continues to develop clinical pathways and other protocols to ensure that physicians apply current standard of care practices at the Facility. The Facility, working with the DADS Central Office, continued to work on clinical	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	pathways that will assist clinicians in managing common and serious clinical issues of individuals served by the Facility. The Facility had proposed an "Aspiration Pneumonia" protocol, to DADS Central office for review. The Monitoring Team reviewed the protocol, and noted its specificity. The Monitoring Team believes that the process could be enhanced by further describing other common variables that occur on occasion in Individuals with disabilities. The Monitoring Team suggests the Facility also consider identifying other important variables for the protocol, including not mounting a robust white blood cell count, until late in the clinical course; not demonstrating infiltrates on chest x-rays because of fluid balance issues, secondary to poor intake; challenges with compliance with oral antibiotics; not demonstrating signs and symptoms of pneumonia until late in the course, as one would expect in the general population; the importance of monitoring for subtle behavior changes that can indicate illness; and the importance for early triage for assertive hospital treatment with assertive fluid management and intravenous (i.v) antibiotics, when clinically indicated. Per review, findings and determination for Provision L.1, and the Facility's continued, uncompleted work towards developing clinical pathways and enhancing generally accepted professional standards of care, the Monitoring Team determines that the Facility is not in substantial compliance with Provision L.4, of the Settlement Agreement.	

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

1. The Facility's medical and nursing staffs need to consistently participate in Mock Medical Emergency Drills to ensure preparedness in responding to medical emergencies.
2. The Facility needs to ensure that Mock Medical Emergency Drill data are reviewed at least monthly and trends analyzed quarterly. Documentation of trends and follow-up on systemic corrections of identified issues must be maintained.
3. The Nursing Department needs to ensure that Control Drug Check Sheets and Equipment Checklists are checked every shift and signed by two nurses.
4. The Facility's managers and supervisors need to ensure that all staff remain current in CPR and Basic Life Support for Health Care Providers (CPR/AED) certifications.
5. The Facility needs to ensure that efforts are made to have an outside physician review clinical records of the decedents' and to attend the Clinical Death Review Committee Meetings.
6. The Facility needs to ensure that all relevant information required by policy is submitted to DADS within the specified timeline and that there is documentation of the submission.
7. Develop policy for Doctor-to-Doctor Transfer Progress Record and ensure full implementation
8. Review and revise the current protocol for the use of oxygen.
9. Provide competency based training for physician and nursing staff on the management and triaging of respiratory conditions, and emergencies. It is essential that clinical staff are familiarized with appropriate management of aspiration, choking, and pneumonia of all causes. Individuals with

intellectual disabilities who develop pneumonia require more assertive management than those in the general public; because of underlying conditions and certain medications, they may not manifest a robust elevated white blood cell count, and because of fluid balance issues secondary to poor intake, they may not develop a visible infiltrate on x-ray, until very late in the course. Importantly, compliance with oral antibiotics may be more challenging for some Individuals with intellectual disability, hence, necessitating the need for i.v antibiotics, early on. Importantly, some individuals with intellectual disabilities do not manifest typical signs and symptoms of pneumonia, until late in the course. All of these issues must be well understood by clinical and direct care staff. Facility leadership should assertively review staff performance and develop outcome and performance measures to address aspiration, choking, pneumonia, and asphyxia.

10. A specific policy or protocol should be developed for the "Preventive Care Flow Sheet". The flow sheet should be reviewed per issues delineated by the Monitoring Team in Provision L.1.
11. Enhance regular assessment of individuals for progressive spine conditions by reviewing current practice standards for assessing individuals with Down Syndrome, consulting with experts in orthopedic spine conditions in Individuals with disabilities, and considering expanding routine assessments to all individuals at the Facility.
12. Enhance routine management and follow-up of persons with diabetes. Ensure that current standard of care practice is offered to individuals who reside at the Facility. Following review of the literature, consider collaboration with an endocrinologist when developing a policy or procedure.
13. Review vaccine and immunization practice at the Facility. Ensure adherence to the CDCs recommendations for all recommended vaccines, and their process of verification of past immunization.
14. Clinicians must enhance their practice by following up on acute clinical issues until full resolution, as well as abnormal diagnostics and consultations.
15. Progress notes must well delineate the individuals conditions, prognosis, and plan. All plans must state when the individual requires follow-up by the physician.
16. All conditions noted, such as in progress notes, problem list and results form diagnostics, must have an associated plan that include frequency of follow-up by the Clinician.
17. The Facility must immediately enhance medical and nursing participation in the PST process. It is imperative that the team be made fully aware of all clinical conditions, prognosis, risks and benefits of treatments, and plan.
18. The Medical Record Audit must be enhanced by ensuring the following: There is assessment to determine that the clinician is practicing within current standard of care practice; there is a mechanism in place to assess outcomes, longitudinally, for trends analysis; a mechanism be in place to ensure appropriate remediation, when necessary; all associated policies and procedures must be complete and fully operational.
19. The Facility must immediately develop and implement a meaningful quality assurance process that will capture medical indicators, such as specific conditions, hospitalizations, EMS calls, deaths, and importantly, data points, such as laboratory and other diagnostic results, that can demonstrate efficacy of clinical practice at the Facility. Data must be maintained longitudinally and enable regularly conducted trends analysis. Quality improvement processes must be developed for identified adverse outcomes, and a mechanism to ensure process improvements are functional.
20. The Facility must also continue to enhance its mortality review process by improving documentation of the reviews, ensure timely reviews by external physicians and developing a mechanism to ensure that recommendations are effective long-term.

The following are offered as additional suggestions to the facility:

1. Consider including CIR information in the Drill Committee discussion with a focus on the timeliness and appropriateness of the staffs' emergency response to Code Blue events.

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. Denton State Supportive Living Center (DSSLC) Plan of Improvement (POI), 3/15/11 and accompanying Section M Presentation Book 2. DSSLC Policy: Quality Enhancement, Policy Number: 003, Date: 11/13/09 3. DSSLC Policy: Quality Assurance/Quality Improvement Council, Policy Number: C and C-2, Date 9/29/10 4. DSSLC Personal Support Planning Process, Policy/Number: CMGT-12.01, Date: 1/3/11, Supersedes: CMGMT-12 5. DSSLC Positive Behavior Support Limitations of Restraint as a Crisis Intervention, Policy and Procedure CMGMT-20 and Exhibits C and D, Date: 11/5/09 6. DSSLC Health Services Dental/Medical Sedation and Restraint Policy and Procedure CMGMT-21, Date Revised: 11/5/09 a. Exhibit B: Pre/Active/Post Sedation Checklist, Date Revised: 5/25/10 b. Exhibit C: REACT Scoring System 7. DSSLC Pharmacy and Therapeutics Committee, Policies and Procedures Manual, Committees and Councils-05, Date Revised: 2/1/10 8. DSSLC Pharmacy Consultation and Oversight Committee, Policies and Procedures Manual, Committees and Councils-09, Date Revised: 11/1/09 9. DSSLC Policy: Nursing Services, Policy Number: 010, Date Approved: 12/7/10, Implementation: 1/31/11 10. DSSLC Procedure: Care Plan Development, Date: 7/2010 11. DSSLC Management of Oxygen Levels (In Individuals who do Not have a respiratory order in place), 8/31/10 12. DSSLC E-mail from Nursing Staff from CNE Regarding Notifying Providers of Acute Illness, 9/28/10 13. DSSLC Procedure: Medication Administration Guidelines, Date: 2/2011 14. DSSLC Nursing Protocol: Seizure Management, Date: Date: 2/2011 15. DSSLC Nursing Protocol: Vagal Nerve Stimulator, Date: 2/2011 16. DSSLC Procedure: Management of Acute Illness and Injury, Date: 2/2011 17. DSSLC Procedure: Nursing Documentation Guidelines: Date: 2/2011 18. DSSLC Standardized Nursing Abbreviations List, Draft 19. DSSLC Procedure: Competency Based Training Curriculum-Agency/Contract Nurses, Date: 2/2011 20. DSSLC Nursing Protocol: Pre-Treatment and Post-Sedation Monitoring, Date: 2/2011 21. DSSLC Division of Nursing, Infection Prevention and Control – Employee Health Services Policy, No Date 22. DSSLC Nursing Education Material: a. Skills Fair Summary, 2/23/11 b. Memory Jogger for Sepsis with Sample Health Care Protocol – Health Maintenance Plan for High Risk for Sepsis used for Training and Competency-based Test for Sepsis Management

	c. "Call a Nurse For..." Poster and Training Materials for Direct Care Professionals d. Comprehensive Nursing Assessment Training Tool - used by Nurse Manager Supervisor 23. DSSLC List of Nursing Standardized Procedures – Protocols – Guidelines 24. DSSLC Training Log – Nursing Standardized Procedures – Protocols – Guidelines, 12/22/10 through 2/23/11 25. DSSLC Nursing Skills Fair Sign-in Sheets, 2/23/11 and 2/24/11 26. DSSLC Nursing Staff Meeting Minutes for Eastfield and Thornhill, 3/16/11 27. DSSLC List of Meeting Dates for Each Registered Nurse Case Manager 28. DSSLC Organizational Charts 29. DSSLC Map of Campus 30. DSSLC Abbreviation List 31. DSSLC Report for Monitors, 3/28/11 32. DSSLC Active Position Report, 2/28/11 33. DSSLC Nursing Supervisors' Daily Shift Reports for last six months 34. DSSLC List of Psychoactive Medications by Patient, 2/16/10 through 2/16/11 35. DSSLC Space and Physical Environment Committee Minutes 7/10/10 through 1/23/11 36. DSSLC Personal Support Plan and Quarterly dates, Printed: 3/9/11 37. DSSLC Settlement Agreement Plan for Nursing, Revised: 12/30/10 38. DSSLC Nursing Monitoring Tools and Guidelines, Revised 1/2011 39. DSSLC Medication Administration and Documentation Checklist, Revised: 2/10/11 40. DSSLC Quality Assurance Department's Process for Determining Sample Size for Settlement Agreement Monitoring Tools, 3/25/11 41. DSSLC Quality Assurance Director E-mail, 3/31/11, to Chief Nurse Executive and Nursing Operations Officer, Subject: Quality Assurance Nursing Audits 42. DSSLC Completed Section M – Medication Administration And Documentation Audits 9/2010 through 3/2011 43. DSSLC Medication Pass – Enteral Feeding Observation List (Schedule) for 2011 44. DSSLC Medication Error Trending Report, 9/9/10 through 3/16/11 45. DSSLC Medication Error Committee Meeting Minutes, 12/31/10, 1/26/11, and 2/17/11 46. DSSLC Monthly Medication Error Corrective Action Reports, 9/2010 through 2/1011 47. DSSLC Pharmacy and Therapeutic Committee Meeting Minutes, 9/24/10 and 12/28/10 48. DSSLC Quality Assurance and Quality Improvement Council Meetings: Data Analysis Report, 10/21/10, 11/18/10, 1/6/11, 1/20/11, 2/17/11, and 3/31/11 49. DSSLC Admission and Separation Activity Report, 9/1/10 through 2/2/8/11 50. DSSLC Lists of individuals with Fecal Impaction and/or Treated for Acute/Chronic Pain, March 2011 51. DSSLC Serious Injury Report, Printed: 2/8/11 52. DSSLC Pneumonia Tracking, 2/27/10 through 2/15/11 53. DSSLC Infirmary Admissions, 3/1/10 through 3/1/11 54. DSSLC Emergency Room Admissions, 2/17/10 through 2/17/11 55. DSSLC Hospital Report, 2/17/10 through 2/17/11 56. DSSLC Slip Trip Fall Report, 2/23/10 through 2/24/11 57. DSSLC Weight – Losses and Increases- Report, 11/9/10 through 1/5/11

	58. DSSLC Weight and Body Mass Index (BMI) Report 59. DSSLC Modified Diet List, Printed: 2/22/11 60. DSSLC Reduction in Continuous Enteral Feeding Times, Last Revised: 2/25/11 61. DSSLC Top 10 Injured, 2/16/10 through 2/16/11 62. DSSLC PICA Report, 2/16/10 through 2/17/11 63. DSSLC Unusual Incident Reviews: Incident Tracking Numbers: 11-057, 11-123, and 11-068 64. Texas Department of Family and Protective Services: Adult Protective Services ICF-MR Facility Investigative Reports (Five-Day Status Reports) Case Numbers: 38350809, 38455296, and 38567489 65. DSSLC Record Request for Section 1 #11.c (number of contractors and number of hours for each discipline), Information as of 2/28/11 66. DSSLC Choking Report, Printed: 2/17/11 67. DSSLC Risk Guidelines and Integrated Risk Rating Form related to At-Risk Individuals Policy 68. DSSLC Comprehensive High Risk Rating for Individuals, Printed: 2/9/11 69. DSSLC List of Individuals at Risk for Aspiration Pneumonia, Rated with the revised At-Risk Individuals Tool according to their Personal Support Plan Schedule, 1/4/11 through 3/16/11 70. DSSLC Aspiration Pneumonia Report, 2011 71. DSSLC Aspiration Pneumonia Graph, 2010 and 2011 72. DSSLC Aspiration Triggers Data Sheet (Blank Copy) 73. DSSLC "Call a Nurse For..." for: Flyer 74. DSSLC Wound Tips 75. DSSLC Lists of Floor Stock Medications for Units and Infirmary 76. DSSLC Medication Administration Times 77. DSSLC Wound Care Services, 3/31/11 78. DSSLC Wound Documentation Tips 79. DSSLC Skin Integrity Meeting Minutes, 12/14/10 and 3/22/11 80. DSSLC Tracking Decubitus Report, 2/23/10 through 2/24/11 81. DSSLC Tracking Decubitus Report – Unresolved, Printed: 3/29/11 82. DSSLC Diabetic Services Coordination, 3/30/11 83. DSSLC Orientation/Preservice Training Schedule, Revised: 3/14/11 84. DSSLC Infection Control Training Curriculum, Revised: 2/1/11 85. DSSLC Infection Control Training: Signs and Symptoms to Report to a Nurse to Prevent Aspiration Pneumonia and Test, 2/1/11 86. DSSLC Completed Monitoring Tools for Hand-Washing with Hand-Washing Instruction Sheet 87. DSSLC Infection Control Rounds Audit Tool 88. DSSLC Infection Control: Employee Illness Tracking Sheet, 11/1010 through 1/2011 89. DSSLC Infection Control Report for Infections, 8/1/10 through 1/31/11 90. DSSLC Infection Control Report for Communicable Diseases by Select Code, 9/1/10 through 2/28/11 91. DSSLC Infection Control Graphs for Infections/Communicable Diseases for 2009 and 2010 92. DSSLC Client Testing Positive for Tuberculosis Report 1/1/10 through 12/31/10 93. DSSLC Infection Control: Drug Utilization Report – Antibiotics, 2/23/11 through 3/23/11 94. DSSLC Infection Control: Immunization Database (sample), Printed: 3/28/11

	95. DSSLC Infection Control: Antibiogram, 2010 96. DSSLC Infection Control: Aspiration Pneumonia Graph, Quarterly Averages for 2010 and 2011 97. DSSLC Infection Control: Tuberculosis (TB) Testing and Chest X-ray Delinquency Report for Individuals, Printed: 3/28/11 98. DSSLC Infection Control: Mantoux or Chest X-ray Delinquency List for Employees, Printed: 3/28/11 99. DSSLC Infection Control: 2011 TB Testing Calendar for Employees 100. DSSLC Infection Control [Committee] Quarterly Reports for October 2010 (Reporting Period 7/1/10 through 9/30/10) and January 2011 (Reporting Period 10/1 through 12/31/10) 101. Record review for Individuals #703, #367, #620, #520, #464, #595, #768, #123, #605, #183, #776, #569, #175, #618, #638, #487, #546, #238, #524, #108, #298, #119, #503, #621, #732, #460, #606, #725 and #12 **People Interviewed:** 1. Delia Schilder, RN, Chief Nurse Executive (CNE) 2. Sherri Courtney, RN, Nursing Operations Officer (NOO) 3. Johanna Hayse, RN, Wound Care/Educator/Specialty Nurses' Supervisor 4. Sibylle Graviett, RN, Nurse Case Management Supervisor 5. Diane Porter, RN, Diabetic Educator 6. Linda Barnett, RN, Nurse Educator 7. Gwen Weiss, RN, Nurse Educator 8. Jacquilin Garrison, RN, Infection Control Nurse 9. Tonya Winget, Garden Ridge West Nurse Manager 10. Hilda Clemente, Eastfield Nurse Manager 11. Dawn Jones, Timberhill Nurse Manager 12. Florinda Igwe, RN, Charge Nurse 13. Sharon Long, RN, Nurse Case Manager, Infirmary North Wing 14. Teresa Chi, RN, Infirmary Triage Nurse 15. Thirteen Nurses and One Psychology Staff interviewed regarding use of active record **Meetings Attended/Observations:** 1. Tour of Infirmary and North Wing, 3/28/11 2. Medication Administration Observation in the Infirmary, at 4:00 p.m., 3/28/11 3. Pharmacy and Therapeutic Committee Meeting, 3/29/11 4. At Risk Meeting, 3/29/11 5. Mortality Review, 3/30/11 6. Quality Assurance and Quality Improvement Committee Meeting, 3/31/11 7. Telephone Conference with Valarie Kipfer, RN, State Office Nursing Coordinator, CNE, and Connie Horton, RN, Nurse Practitioner Consultant, 3/31/11 8. Medication Administration Observation, Garden Ridge - West, at 12:00 noon, 3/31/11
	Facility Self-Assessment: Based **t**he Facility's POI, the Facility reported they were not in compliance with any of provisions in Section M of the Settlement Agreement. While Facility stated they were not in compliance with this section, it was apparent through interviews, observations, and document review as well as review of the Nursing Section

	of the POI, that the Nursing Department had made many improvements in implementing new systems and in strengthening existing systems. The review of the Nursing Presentation Book addressed the Settlement Agreement requirements and the 44 recommendations that grew out of the last review; they provided detailed supporting documentation validating each of the 44 recommendations. This was most impressive. The Presentation Book with the detailed information and timelines for completion facilitated the review process and provided a comprehensive overview of the steps the Nursing Department had taken, the progress made, and the status of where they were in meeting compliance with the Settlement Agreement.
	Summary of Monitor's Assessment: It was readily apparent since the last review that the Nursing Department had made significant progress toward meeting compliance with all provisions of Section M. This was most notably related to the outstanding leadership and management style demonstrated by the Chief Nurse Executive and the Nursing Leadership Team. While the CNE acknowledged that the Nursing Department was not in compliance with any of the provisions set forth in Section M of the Settlement Agreement, it was evident to the Monitoring Team that diligent efforts toward compliance had been made during the last six months as was demonstrated through interviews, observations, review of clinical records, and other documents. The areas of improvement put into place since the last review should lead to continued improvements in all provisions for Section M. The Monitoring Team concurred with the Facility's POI that they were not in compliance with any of Section M provisions. Areas of improvement identified as well as areas that need continuing improvement were reflected in the report's provisions below. Provision M.1: Since the last review the Nursing Department had added three RNs to the 10-6 shift to cover all areas of the campus. There continued to be a decrease in the use of agency nurses. The agency contract had been revised to a "Temp to Hire" Contract. Ten nurses were in "Temp to Hire" positions. There were two new Nurse Educators. Disappointingly, the living Units did not consistently meet the established nurse to individual ratio for each shift. The Infirmary rarely ever failed to meet the established nurse to individual for each shift. Remarkable improvements were found in the organization and structure of the Nursing Department in working with the Quality Assurance Department in completing the newly revised 12 Nursing Monitoring Tools. Since July 2010 approximately 567 monitoring tools had been completed monthly. An organized approach was used to select randomized records for the monitoring. The Quality Assurance Department selected and assigned the Nursing Department 5% (approximately 27 records) of the total population to monitor each month. Data were being collected, graphed, analyzed, and reported to the Quality Assurance and Quality Improvement Council monthly for review and discussion. The CNE reported that the Nurse Case Manager used a peer to peer review approach and have found it to be helpful in self-monitoring and making improvements. Data were analyzed for the Facility as a whole but also by living area, which identifies where improvements are most needed. The revised monitoring tools had only been in use since January 2010 and not enough data had been entered to begin developing corrective action plans. Since the last review significant improvements had been made in promptly assessing individuals with acute illness and injury, notifying physicians, and documentation. The Wound Care Nurse and Diabetic Educator

	Nurse contributed significantly to providing specialized nursing care as did the Hospital Liaison Nurses. In March 2011 the Diabetic Educator Nurse began coordination of services and care on a continual basis through the following activities: Coordination of services, daily rounds, monthly summaries, Endocrinology visits with individuals, Diabetic supplies and management and prevention of Diabetic emergencies, and campus-wide Diabetic Education. The Infection Control Nurse continued to track infectious and communicable diseases. However, the Infection Control Nurses could benefit from technical assistance to improve the analysis and trending of infection control data. The responsibilities of the Infection Control Program are comprehensive and multifaceted, particularly in a facility as large as DSSLC. The Facility could benefit from having another Infection Control Nurse to assist with the program. While many improvements had been made and many others are in process, the Monitoring Team concurs with the Facility's POI findings that they are not yet in compliance with the Settlement Agreement. Provision M.2: The Nursing Department has made improvements in the Comprehensive Nursing Assessments through additional training and monitoring but still has an opportunity for continuing improvement. The greatest challenge for the Nurse Case Managers is the ability to analyze raw clinical data and to apply in making clinical decisions to evaluate individuals' health status and for future planning purposes. The State Office was in the process of implementing Physical Assessment and Planning Training, which should assist greatly in improving the quality of the nursing assessments and plans of care. While many improvements had been made and many others were in process, the Monitoring Team concurs with the Facility's POI findings that they are not yet in compliance with the Settlement Agreement. Provision M.3: The Nursing Department continued to use the Health Care Protocols for Developmental Disability Nurses. While these protocols serve as good reference they should only be used as a guide in developing health care plans. Health Maintenance Plans and Acute Care Plans need to be individualized to meet the unique needs of individual health care conditions. The Physical Assessment and Planning Training should assist greatly in improving the quality of the plans of care. While many improvements had been made and many others are in process, the Monitoring Team concurs with the Facility's POI findings that they are not yet in compliance with the Settlement Agreement. Provision M.4: Since the last review numerous polices, procedures, and processes had been put into place. The two Nurse Educators had done an outstanding job with reorganizing and enhancing competency-based training for the nursing staff as well as providing training to the direct care professional staff. A database had been added since the last review for tracking training and projecting timelines for nurses who were delinquent in required training. The Nurse Educators were continuing to develop and implement new training materials. When the Physical Assessment and Planning Training is implemented the Nurse Educators will be responsible, with oversight of the Nurse Practitioner Contract Consultant to conduct the training at the Facility. The Acute Illness and Injury Nursing Care Flow Chart developed through a

	statewide workgroup was impressive and should provide the nurses with a visual cue for decision-making. While many improvements had been made and many others are in process, the Monitoring Team concurs with the Facility's POI findings that they are not yet in compliance with the Settlement Agreement. Provision M.5: Since the last review the At Risk Individuals Policy had been implemented. The Nurse Case Managers along with the physicians/nurse practitioners were responsible for assessing medical/health risk factor. This policy began in January 2011. Conducting the risk assessment at the Personal Support Team meeting with staff who knew the individuals' best and having more time to complete the risk assessment and develop a Risk Action Plan should greatly improve the reliability of the risk derived from the assessment as well as the quality of the Risk Action Plan. The process was too recently implemented to fully evaluate the effectiveness at this time. While many improvements had been made and many others are in process, the Monitoring Team concurs with the Facility's POI findings that they are not yet in compliance with the Settlement Agreement. Provision M.6: Since the last review significant improvement had been made in the medication administration system. Most impressive was the Facility's ability to find building space to provide individuals privacy when they receive medication. Administering medication in areas free from traffic and distraction along with the direct care staff assisting the nurse during medication passes will no doubt assist individuals to feel more comfortable as well as help reduce medication errors. The database for tracking and trending medication errors had recently improved to collect more data from the Medication Error Reports. Medication errors can now not only be tracked by type and category of risk but by unit, shift, nurse, individual, and probable causes. This depth of information will be valuable in analyzing data to develop individual as well as systemic corrective plans of action. This was still a work in progress. Since the last review the Pharmacy was able to modify the WORx computer system to add on to the Medication Administration Record the number of pills required to equal a total dose. This was a significant improvement and should help reduced medication errors. The Pharmacy was also in the process of adding the MAR medications that need to be crushed when individuals were prescribed an alteration in their diet textures. This was a positive finding that will aid in the prevention of individuals choking on medication because the texture was not compatible with their prescribed texture. While many improvements had been made and many others are in process, the Monitoring Team concurs with the Facility's POI findings that they are not yet in compliance with the Settlement Agreement.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18	Provision M.1 of the Settlement Agreement includes a variety of different nursing sub-section requirements that address various areas of compliance. These sections include staffing, quality assurance and peer to peer review efforts, documentation and	Noncompliance

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	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.	accessibility of clinical records, acute illness and injury findings, and infection control information. Information addressing Mock Medical Emergency Drills and Emergency Response Systems are included in Section L.1. Information addressing Death Reviews is included in Section L.2. <u>Staffing</u> It was positive to find since the last review there had been an addition of three RN positions on the 10-6 shift that provided RN Charge coverage to all areas of the campus. In addition, two experienced Nurse Educators had been added to the Nursing Leadership Team. The Nursing Leadership Team remained stable, was motivated, and maintained cohesive working relationships with each other. The Nursing Leadership Team also demonstrated a collaborative and cohesive working relationship with other disciplines. According to the Facility's Active Position Report at the time of the review the Nursing Department's nursing staffing indicated there were 100. RN positions filled, with 36 vacancies. There were 82 positions for Licensed Vocational Nurses (LVNs), with five LVN vacancies. The structure of the Nursing Department remained the same as reported at the last review with the exception of the additional Nurse Educator. The CNE related the future possibility of using the results of the completed At Risk Individuals assessments to identify acuity levels. The acuity level of individuals would be used to better determine nursing ratios and to realign nursing staffing patterns. The Chief Nurse Executive reported that the use of agency nurses had been converted from a long-term contract to a Temp-to-Hire contract. The use of agency nurses had been reduced since the last review. The hours of agency nurses had decrease from 4896 LVN hours and 3314 RN hours in September 2010 to 3049 LVN hours and 1334 RN hours in February 2011. They had 10 agency nurses in "Temp to Hire" status and used less than 30 agency nurses. The CNE projected a target date of 8/1/11 to have filled the "Temp-to-Hire" nurses into permanent positions. Review of the Nursing Supervisors' Daily Shift Reports for the last six months revealed that the established minimum nursing staff ratios to individuals were not consistently met for all living units. The Infirmary was the exception, and rarely failed to meet the established nursing staff ratios. The scope of the Infection Control Program was comprehensive and multifaceted; it went beyond clinical services to include infection control issues in other service areas such as food services, maintenance, housekeeping, environmental control, laundry services, waste management, resident activities, safety, emergency preparedness and employee heath to list a few. In many of the State Supported Living Centers their Infection Control Programs have two Infection Control Nurses and/or an Assistant Infection Control	

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		Nurse. Considering the size of DSSLC the Facility and Nursing Department should consider assigning another RN to the Infection Control Program to ensure that all aspects/requirements of the Infection Control Program are effectively and efficiently carried out. The Nursing Department needs to continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement as well as meeting the established minimum nursing ratios. <u>Quality Assurance and Peer to Peer Review Efforts</u> Since the last review the Nursing Department had made significant progress in their organization and implementation of the quality assurance and peer to peer review processes relating to the use of the Settlement Agreement Nursing Monitoring Tools. However, the processes were still being refined. According to the Facility's POI, the Nursing Department reported that using the 21 Nursing Monitoring Tools, the Nurse Case Managers had completed review of 5% of the population for a total of approximately 567 monitoring tools each month. The analysis of the monitoring tools indicated inconsistencies in data collection. Since the last review the 21 Nursing Monitoring Tools were revised and reduced by the State Office to 12 more user-friendly versions. Interpretive Guidelines were developed for each of the Nursing Monitoring Tools that identified specific criteria that constituted compliance with each item on the tool as well as ensuring that all monitors are consistent in evaluating data. The Facility began using the revised Nursing Monitoring Tools on 1/1/11. Denton SSLC Policy CMGMT-15 Quality Enhancement Process dated 1/5/10 guides the Facility's quality assurance processes. The Facility did have a Quality Assurance/Quality Improvement Council Policy, Policy Number: C and C-02, Date: 9/29/10 that was implemented and functioning to review the outcome of the completed and analyzed monitoring tool. The Facility did not as yet have a fully organized and operational system for the development, implementation, and tracking of corrective action plans. Refer to Section E for details of the status of the Facility's Quality Assurance Plan. The Quality Assurance Department's process for record selection for the Nursing Department and the Nursing Department's plan for completing the Nursing Monitoring Tools were carefully thought through and well organized to efficiently and effectively monitor records as well as to internally analyze as a matter of self-monitoring nursing practices. The CNE and Nursing Leadership attended and participated at the Quality Assurance/Quality Improvement Council Meeting. These processes are described below:	

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		The process used by the Quality Assurance Department for selecting records for the assigned Nurse Case Managers and Specialty Nurses to monitor included: • The Quality Assurance Director generated randomly selected list for 12 months by using the number of individual residing on campus in August 2010. The website RANDOM.ORG - Integer Generator was used to randomly select the records. • During the fourth week of the month the current list of individuals selected to monitor was generated by the Quality Assurance Director. • The Quality Assurance Director assigned 5% (currently 27) of the population to the Nurse Case Manager in the order they appear on the generated list. • The Quality Assurance Director published this list the last couple of days of the month and provided it to the Nurse Case Managers via e-mail. The Nurse Case Managers reviewed each others records, as peer reviewing another peer's records. The CNE related that the Nurse Managers' found the process of peer to peer review beneficial in self-monitoring and resolving issues at the lowest level. • The Quality Assurance Director had started a new process for tracking all completed monitoring tools by the Nursing Administrative Assistant to ensure that all monitoring tools have been received before the section leaders picked up their section for analysis and roll-up report. • The Nursing Department Administrative Assistant made a copy of each set of monitoring tools for distribution to the Nurse Case Managers whose individuals had been reviewed. After the section leaders completed analyses of the monitoring tools for their section, the information was given to the Data Analyst for data entry. • The Data Analyst performed calculations on the data deriving the percentage of compliance with each item on the tools and developed graphs representing the data along with a narrative report. The final information was presented at the monthly Quality Assurance/Quality Improvement Committee Meeting for discussion and disposition. • The Quality Assurance Nurse was assigned the number of the monitoring tools for inter-rater reliability review. The number/percentage of the monitoring tools assigned to the Quality Assurance Nurse was not made available for review nor was how these tools were incorporated into the final report made available. The Nursing Department's Plan for completing the 12 Nursing Monitoring Tools included: • Each of the Specialty Nurses, Nurse Managers, and Nurse Case Manager Supervisor were each assigned as a Section Leader for a specific monitoring tool. • The timeline for completion of the monitoring tools was:	

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		o The first week of the month the Nurse Case Manager Supervisor sends the assignments received from the Quality Assurance Department and the due date to the Nurse Case Managers. o The Nurse Case Managers complete the monitoring tools and return the results to Nursing Administration by the due date. o The third week of the month the Section Leaders analyze data and prepare a report. o All original completed monitoring tools are taken to Settlement Agreement Coordinator and the Data Analyst for data entry. o The fourth week of the month the group meets to discuss sections of the monitoring tool related to the Settlement Agreement. o The cycle repeats itself monthly. DSSLC has had a Quality Assurance/Quality Improvement Council in place for several months. The Monitoring Team observed a meeting of this group during the review. A report was prepared for presentation at the meeting that included quantitative monitoring data on several provisions of the Settlement Agreement. The reports were organized so each provision of the Settlement Agreement was reviewed quarterly by the Quality Assurance/Quality Improvement Council. The Facility also identified a set of key indicators they believed should be used to track organizational performance overtime. Data regarding the key indicators were also reviewed in the Quality Assurance/Quality Improvement Council. These reports were presented at the meeting with some discussion on some areas, primarily consisting of a "question and answer" dialogue rather than a more substantive "how do we improve" dialogue. As this Quality Assurance/Quality Improvement Council process matures it will be important that it generate process improvements within the organization. The CNE explained that when the Nurse Case Managers conducted monitoring, a peer to peer review process was used, e.g., Nurse Case Managers reviewed each others records. She stated that the Nurse Case Manager found the peer to peer review process very helpful in identifying problems as a manner of self-monitoring and correction. This was a very positive finding since problems are best corrected/resolved at the lowest level. The Facility had set the threshold for compliance with each item on the tools and for overall compliance at 80% to begin with and will continue to raise the threshold level as compliance improves. Since the last review it was positive to find the amount of progress the Nursing Department had made toward completing the Nursing Monitoring Tools as well as the overall percentage of compliance achieved with the tools. In addition to identifying the percentage of compliance, they were beginning to specifically identify items within the tools that fell below the 80% threshold. While no formalized corrective action plans had	

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		been developed at this point, these data provided the information necessary from which to develop corrective plans of action. Review of the Section M data reports presented to the Quality Assurance/Quality Improvement Council for 1/6/11, 1/20/11, 2/17/11, and 3/31/11 revealed the following percentage of compliance of Nursing Monitoring Tools analyzed and reported: • Reports for 1/6/11 and 1/20/11 contained data collected July through December 2010 using the older version of the Nurse Monitoring Tools. The CNE stated that the analysis of the monitoring tools completed during this time period (July through December 2010) indicated inconsistencies of data collection. She stated with the use of the revised monitoring tools and interpretive guidelines in January 2011 the data were expected to be more consistent and accurate. Therefore, the Monitoring Team did not review monitoring data collected July through December 2010. • The Quality Assurance/Quality Improvement Council Report for 2/17/11 contained data extrapolated from the revised Nursing Monitoring Tools that was considered more consistent and reliable. The results of the data for January 2011 indicated the following percentages of compliance with the various Nursing Monitoring Tools completed and analyzed: o Nursing Care - Annual Nursing Assessments – overall compliance was 87%. Twenty-three of these instruments were completed by the Nursing Department. This represented a 4.2% sample of 536 individuals that resided at DSSLC. o Nursing Care - Nursing Care Plans – overall compliance was 82%. Twenty-three of these instruments were completed by the Nursing Department. This represented a 4.2% sample of 536 individuals that resided at DSSLC. o Nursing Care - Documentation – overall compliance was 85% - Twenty-three of these instruments were completed by the Nursing Department. This represented a 4.2% sample of 536 individuals that resided at DSSLC. o Nursing Care - Management of Chronic Respiratory Distress – overall compliance of 85%. One instrument was completed by the Quality Assurance Department. This represented a 0.2% sample of the 536 individuals who resided at DSSLC. o Nursing Care - Medication Administration and Documentation – overall compliance was 98%. Six instruments were completed by the Quality Assurance Department. This represented a 1.1% sample of the 536 individuals that resided at DSSLC. o Nursing Care – Prevention - overall compliance was 98%. Twenty-four instruments were completed by the Nursing Department. This	

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		represented a 4.5% sample of the 536 individuals who resided at DSSLC. o Nursing Care – Seizure Management – overall compliance was 79%. Twelve of these instruments were completed: One by the Quality Assurance Nurse and 11 by the Nursing Department. This represented a 2.2% sample of the 536 individuals who resided at DSSLC. • The Quality Assurance/Quality Improvement Council for Report for 3/31/11 reported the results of data collection and analysis for January and February 2011. Listed below are the percentages of compliance derived from the various Nursing Monitoring Tools completed and analyzed: o Nursing Care – Acute Illness and Injury – overall compliance was 86%. Twenty-six instruments were completed by the Nursing Department and two were completed by Quality Assurance Department. This represented a 4.8% sample of 535 individuals that resided at DSSLC. It was noted that two areas fell below 70%: ▪ M-AII.3- monitoring items: 1. There is evidence that the nurse fully utilized the nursing process when monitoring an acute episode by performing appropriate assessments as dictated by the affected or related system(s). 2. Creating/modifying/implementing a nursing care plan as needed to address changes in the individual's condition. Conducting frequent evaluations of the individual's clinical condition to ensure the appropriateness of treatments and facilitate the individual's recovery. This item met 69% compliance. ▪ M-AII.8 - monitoring item: An Acute Care Plan was developed including instructions for implementation and follow-up evaluation(s). This item met 67% compliance. o Nursing Care - Infection Control – overall compliance for January was 93% and for February 94%. Twenty-five of these instruments were completed by the Nursing Department. This represented a 4.7% sample of 535 individuals that resided at DSSLC. It was noted that two items on the Infection Control Monitoring tool fell below 70%: ▪ M.IC-OIC.1: Dropped the furthest between the months of January and February falling below 70%. ▪ M.IC-OIC.1 - monitoring item: When antibiotic therapy has been prescribed, there is documentation that nursing staff have: Conducted a comprehensive evaluation specific to the presenting condition or diagnosis at least daily during the first 72 hours while the individual is receiving antibiotic therapy for an acute illness. The evaluation addresses the efficacy of the treatment and any side effects the individual may develop. This	

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		item met 60% compliance. o Nursing Care – Pain Management – overall compliance for January was 85%. Documentation was not available regarding sample size. It was further impressive that the data derived from Nursing Monitoring Tools not only analyzed the percentage of compliance with each item on the tools but also the overall compliance with each tool, and the data were also analyzed for percentage of compliance for each of the living areas. By analyzing data for compliance with each living area the Nursing Department was able to identify specifically which living area fell below the 80% threshold of compliance with the monitoring tools. This focus assisted the Nursing Department in identifying where corrective action plans were most needed. The information provided for review of the living area data were represented in a bar graph with the percentage of compliance with the various tools represented on the vertical line with the number of the living areas represented on the horizontal line. Single lines were drawn horizontally across at 80%. Therefore, visually it was possible to readily identify which living areas fell below the 80% threshold. The overall compliance for each tool was also graphically represented. Example of living areas falling below 80% for the reporting period 10/1/10 through 3/17/11 are listed below for each Nursing Monitoring Tool analyzed: • Nursing Care- Documentation o 509C o 523D o 525D • Nursing Care – Management of Chronic Conditions: Skin Integrity Assessments o 508C o 509A • Nursing Care – Management of Chronic Conditions: Incontinence and Urinary Tract Infection o 506A o 523B o 526B o 528D • Nursing Care: - Management of Chronic Conditions: Hypertension o 527B • Nursing Care – Management of Chronic Conditions: Gastroesophageal Reflux Disease (GERD) o 505C o 527B • Nursing Care – Management of Chronic Conditions: Bowel Management o All living areas were reported above 80% compliance	

#	Provision	Assessment of Status	Compliance
		• Nursing Care – Management of Chronic Conditions: Aging and Individual with Developmental Disabilities (DD) o All living areas were reported at or above 80% compliance • Nursing Care – Seizure Management o 503B • Nursing Care – Pain Management o 505C o 506C o 509A o 524C o 526B o 528B • Nursing Care – Infection Control o 507C o 509A o 510B o 515B o 523B o 526D • Nursing Care – Diabetes o All living areas were reported above 80% compliance • Nursing Care – Annual Nursing Assessment o All living areas were reported above 80% compliance • Nursing Care – Acute Illness and Injury o All living areas were reported above 80% compliance • Nursing Care – Management of Chronic Respiratory Distress o All living areas were reported above 80% compliance • Nursing Care – Quarterly Nursing Assessments o 502D o 506A o 510B o 526C • Nursing Care – Psychotropic Medications o 506A o 509A o 531C o 526D o 527B o 528D • Nursing Care – Protection from Harm – Restraints	

#	Provision	Assessment of Status	Compliance
		o 507A • Nursing Care – Prevention o 509A • Nursing Care – Pharmacy Services and Safe Medication Practices o 514B • Nursing Care – Health Care Plans o All living areas were reported above 80% compliance It was important to point out that the above data analyses included data from October, November and December 2010 that the CNE stated contained inconsistent data. The Facility began using the Interpretive Guidelines for the monitoring tools in January 2011. Use of these guidelines should improve the consistency and quality of data collected among staff completing the monitoring tools. The implementation of inter-rater liability checks performed by the Quality Assurance Nurses should also improve the quality and reliability of the data derived from the monitoring tools. The detailed inclusion of the Quality Assurance and Nursing Departments' data analyses reports for the Nursing Monitoring Tools served a twofold purpose; it demonstrated the progress made toward compliance with the Settlement Agreement's requirement for quality assurance as well as a benchmark for future reviews by the Monitoring Team. By the next review the Nursing Department should have generated enough reliable data to begin developing and implementing corrective action plans. The Nursing and Quality Assurance Departments need to ensure that the nursing staff completing the Nursing Monitoring Tools critically evaluates clinical issues with the focus on the quality of nursing services and supports, e.g., the appropriateness and efficacy of the care rendered to meet individuals' unique health care needs, as opposed to merely checking off the items contained on the tools. <u>Assessment and Documentation of Individual with Acute Changes in Health Status</u> Listed below is one of numerous examples that demonstrated that since the last review the nurses were beginning to follow and document acute illnesses through to resolution according to protocol. Individual # 367 was diagnosed with acute pharyngitis on 1/24/11 and treated with Chloraseptic sprays, two sprays to throat every four hours for 72 hours and Tylenol 650 milligrams, every six hours times 72 hours, as needed for sore throat. Review of Individual #367's Integrated Progress Notes, 1/24/11 through 1/31/11, indicated that the nursing staff completed assessments and follow-up every shift for 72 hours and at least daily after that, with the only day missed being 1/30/11. On 1/31/11 a resolution note was written. There was evidence of appropriate documentation and follow-up until	

#	Provision	Assessment of Status	Compliance
		resolution except the one day that was missed, which was on a Sunday. Frequently Individual #367 refused the assessments and only temperatures were taken but the method of temperatures were not documented. <u>Skin Integrity/Wound Care Management</u> It was positive to learn since the last review that the Facility Director, Medical Director, and CNE had met with Denton Regional Medical Center's CNE regarding individuals who were served by the hospital. The CNE related that the purpose of the meeting was to improve communication and collaboration with the hospital. This was necessary because of several concerns that included an increase in hospital acquired skin breakdown/decubitus ulcers and aspiration pneumonia as well as the difficulty in Hospital Liaison Nurses having access to individuals' records, and delay in receiving hospital records, particularly after the death of an individual. The Facility sends direct care professionals or employed private sitters to stay with hospitalized individuals. The hospital limited the care that the Facility's direct care professionals and private sitters were permitted to provide to individuals in the hospital. As result of the meeting an agreement was reached where the Hospital Liaison Nurses will become credentialed to have access to individuals' hospital records. The Facility's direct care professionals will be able to assist individual in the bed with positioning and other care that can be provided in the bed. They will not be allowed to get individuals out of bed. The private sitters will not be allowed to assist individuals in any way. If the Hospital Liaison Nurses identify problems with skin care, they will notify the DSSLC Wound Care Nurse who will contact the hospital's Skin Care Nurse to follow-up on concerns. The Wound Care Nurse provided the Monitoring Team with a list of her responsibilities related to coordinating wound care with various disciplines as follows: • Coordination of Care: Daily attendance of Morning Rounds: Skin integrity issues were discussed as they arise whether in the hospital, Infirmary or on the various units. When the Hospital Liaison Nurses suspect an issue, find a problem, or just need help getting the right people to respond, they inform the Wound Care Nurse of the situation. The Wound Care Nurse contacts the hospital Director of Wound Care via email and/or telephone to have her look into the situation. This is a great resource for DSSLC in ensuring individuals in the hospital receive appropriate treatment for wound and/or skin integrity issues. The hospital Wound Care Director calls the DSSLC Wound Care Nurse to discuss her plan for the individual and provides a progress report. The Infirmary charge nurses inform the Wound Care Nurse if individuals begin to have skin integrity issues so that a plan of care can be developed. They also call when an individual who had a wound or skin integrity issue is readmitted to	

#	Provision	Assessment of Status	Compliance
		the Infirmary from a hospital or long term acute facility. The physicians and nurse practitioners also notify the Wound Care Nurse when issues are noted with individuals they serve. She explained that this collaboration had taken some time to achieve but it was apparent by the number of referrals they made that they were routinely utilizing her as a resource. • Committee Meetings: The Wound Care Nurse chaired the Skin Integrity Committee that met quarterly and as needed in the event that a situation arose that needed immediate attention. The committee consisted of: Physician, Nurse Educators, Nurse Case Managers, Quality Assurance Nurse, Pharmacist, CNE, Nurse Case Manager Supervisor, Habilitation Therapist, and Dietitian. During the meetings, the current decubitus, resolved decubitus, treatments, positioning situations and brain storming issues were discussed to aid in individuals' wound healing. The committee also evaluated for possible trends of skin breakdowns. The Wound Care Nurse gave an example of how the committee collaborates on care. An individual who had a chronic superficial breakdown to the shoulders, ischial tuberosity, and coccyx at varying times developed a state IV ulcer that stared as a deep tissue injury. The wounds became deep and required Vacuum Assisted Wound Closure (VAC) Therapy to close the wound. A grade III specialty mattress was purchased for him as well as an intensive positioning schedule was implemented to aid in the relief of the pressure. The wound was healed in May 2010 and he had no further skin breakdown. This was one of many success stories shared by the Wound Care Nurse. The Skin Integrity Committee was recently incorporated into the Physical and Nutritional Management Committee. The Wound Care Nurse served as a member of this committee as well as on the Infection Control Committee and Professional Practice Counsel. She also assisted with referrals from the Personal Support Team. • Monthly Summary: At the end of the month the Wound Care Nurse summarized the newly acquired decubitus either at the Facility or at outside facilities. This Report was sent to the Data Analyst. • Outside Wound Care/Surgical/Orthopedic Appointments: When individuals need referral to the off-site Wound Clinic the Wound Care Nurse accompanies them to their appointments. She explained that she has an excellent working relationship with the Wound Care Doctor and staff. When individuals need to be seen quickly they were scheduled within a couple of days. The clinic director contacted the Wound Care Nurse directly when they needed information passed to the physicians and/or if there was a critical lab reported that needed to be	

#	Provision	Assessment of Status	Compliance
		addressed by the physicians. • Education: Education was an ongoing service in the Facility. Skin integrity issues, wound care treatments, staging of decubitus, measuring, and proper documentation training was presented at the Nursing Skill Fairs. Informal training was done with nurses caring for individuals with skin breakdown and/or wounds. For example, when there was a specific packing technique that was used it was explained in detail on the orders as well as explained to the nurses who primarily worked in the apartment where the individuals reside. Direct care professionals were routinely instructed to report any skin irritation, redness, warmth, swelling/edema as well as specific issues that required nursing attention regarding soiling or dislodging of dressings ad/or signs of pain or discomfort the individuals may experience. • Integration of Services: The Wound Care Nurse explained that it was crucial for the outcome of the individuals' care that all services work together to restore individuals to pre-illness health. Once the Wound Care Nurse was notified of a confirmed or potential alteration in skin integrity by any discipline, she assessed the situation and made the proper referrals. The most frequent referrals were made to the Habilitation Therapy and Dietary Departments. The Wound Care Nurse explained that Habilitation Therapy "worked miracles" in changing positioning schedules, modifying wheelchairs, creating positioning apparatus, and ordering/providing specialty mattresses when indicated to assist individuals successfully heal. Dietary assessed the nutritional requirements and made additions when needed. Juven was a supplement used to aid in healing when there were nutritional deficits or when the individuals needed extra help with healing. Other referrals for wound management included follow-up instructions to the Nurse Case Managers, Physicians, and Residential Program Directors. Over the last year the increase in the incidents of hospital acquired skin breakdown/decubitus ulcers was validated through review of the Facility's Decubitus Tracking Report, 2/23/10 through 2/24/11 and Decubitus Tracking Report – Unresolved, 3/29/11 as well as the decubitus graph presented in the Section O Report for Monitors, 3/28/11. The graph represented skin breakdown/decubitus acquired in the hospital and at the Facility. There were a total of 45 incidents of breakdown/decubitus ulcers of which 22 (49%) were hospital acquired, 20 (44%) were acquired at the Facility, and 3 (7%) were acquired in a long term acute care facility. Compared to the last review there had been a reduction in the incidents of skin breakdown/decubitus from 71 to 45 incidents. Even with the reduction in the incidents of skin breakdown/decubitus, there needs to be continuing efforts to eliminate all incidents. Monitoring Team will follow-up at the next tour to determine if the enhanced communication and collaboration, and ability of the direct care professionals to assist	

#	Provision	Assessment of Status	Compliance
		hospitalized individuals with positioning have reduced the incidents of hospital acquired skin breakdown/decubitus ulcers. As was identified during past reviews, the Wound Care Nurse continued 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 Wound Care Nurse followed up on referrals for pressure ulcers and/or wounds at least weekly or as indicated. The Wound Care Nurse worked with nurses during the Nursing Skills Fair to provide education on assessment, staging pressure ulcers, and treatment modalities used in wound care management. The units' primary care nurses assessed pressure ulcers and/or wounds daily or at the time of treatment in accordance with physician orders. At the time of the review there were five unresolved decubitus of which two were stage II, two were stage III, and one was a deep tissue injury. Review of records for Individuals #768, #464, and #595 and observations of Individuals #768 and #595 identified the following: • Individual #595: At the time of the last review, Individual #595 had two stage IV pressure ulcers of the right and left popitial fossa (back bend of knees) caused by wearing Thrombo Embolic Deterrent (TED) hose compounded with contractures of the knees. Aggressive wound care management was being provided by the Wound Care Nurse, Habilitation Therapy staff, Wound Care Physician, Dietitian, nursing staff, and direct care professionals. While onsite this tour the Monitoring Team observed Individual #595 to assess wound healing status. It was positive to find that Individual #595's bilateral decubitus of the popitial fossa were completely healed. This was a real success story demonstrating the true meaning of integrated services. It took the teamwork of many disciplines coming together to care for Individual #595's pressure ulcers. Individual #595's popitial fossa pressure ulcers were so deep that the underlying tendons were exposed increasing the likelihood of serious infections and/or requiring surgical intervention. Because of the team's diligent management of Individual #595's wound care, by completing thorough assessments, adjustment in positioning schedule and wheel chair adjustments, proper positioning, and assurance of adequate nutrition, Individual #595's wounds healed without complication of infection or surgical intervention. • Individual #768: Review of Individual #768's record indicated that he was admitted to Denton Regional Medical Center on 3/10/11 for a laparoscopic cholecystectomy. He was discharged on 3/15/11 and admitted to the Infirmary. At the time of admission, Individual #768 was found to have two abrasions on the dorsal surface of the left foot, apparently secondary to tape burns from an intravenous infusion, and a two inch intact blister on the left heel. A Nursing Care Plan was established for Skin Impairment on 3/15/11. The Infirmary used	

#	Provision	Assessment of Status	Compliance
		the older version Nursing Care Plan before the use of the Health Care Protocols for Developmental Disability Nurses. The plan was generic and was not individualized to address the blister on the dorsal surface of the left foot and the blister on the left heel. The plan did state to monitor every shift. Review of the Integrated Progress Notes indicated that Individual #768 was appropriately assessed every shift and treatment applied to wounds. Individual #768 returned home 3/17/11. The home nursing staff continued to assess and manage the wound care every shift. However, the wounds were only assessed as "no drainage, no signs and symptoms, dry 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 Wound Care Nurse had developed a comprehensive Wound Documentation Tips Sheet that provided the nursing staff detailed instructions describing how to recognize various stages of wounds and how to document the description of wounds, including instructions for measuring the size of the wounds. The sizes of wounds were to be measured in centimeters and the length, width and depth were always to be documented. Standardized measuring techniques are necessary to provide quantitative information on wound healing. The Nursing Department and Wound Care Nurse need to ensure that when the nursing staff assess the healing status of wounds that they always measure the size, including the length, width, and depth of wounds for comparative purpose over time. On 3/21/11 the physician assessed the wounds and found the size of the blister on the left heel had increased and the abrasion on dorsal left foot had developed blisters. The physician ordered the Wound Care Nurse to see Individual #768 that day. The Wound Care Nurse assessed Individual #768 on 3/12/11 at 1200. She assessed blister on the left heel as fluid filled measuring 4.3 centimeters (cm) by 4 cm by 0 cm with suspected deep tissue injury and the left dorsal blisters measured 7 cm by 0.5 cm and 7 cm by 4 cm with possible infiltrate. She made a referral to Habilitation Therapy for a positioning assessment because Individual #768 was digging his heel into the recliner. The Wound Care Nurse developed an Acute Care Plan using the Health Care Protocol for Developmental Nursing and individualized it to meet Individual #768's need for wound care. The nursing staff and direct care professionals were instructed in the plan. The treatment order was for Betadine swab twice a day for 10 days, cover with a gauze dressing to blisters. The plan was carried out and the Habilitation Therapy assessed and modified the seating positioning in the recliner and there was evidence that the wounds were beginning to heal. The Skin Integrity Nurse assessed the wounds at least weekly and more often when indicated. On 3/29/11, the Monitoring Team observed the Wound Care Nurse change	

#	Provision	Assessment of Status	Compliance
		Individual #768's dressing, using clean technique. The wounds were dry and showed evidence of healing. The wound on the left dorsal foot measured 6cm by 1.5 cm and the left heel measured 4 cm by 4 cm. The wounds were cleaned and swabbed with Betadine and gauzed dressing applied. The left foot was placed in a waffle boot with the heel of the boot open. After the dressings were changed the Wound Care Nurse provided instructions to the direct care staff to make sure that the waffle boot was open to the heel and that Individual #768 maintained good alignment in the recliner to keep the pressure off his heel. Instructions were also written in the 24 Hour Log. The only concern identified was that after the dressing was removed the Wound Care Nurse laid the dirty dressing on the floor. After the dressing was changed the Wound Care Nurse removed the dirty dressing and took it out of the room for disposal. The dirty dressing should have been placed in a closed container after removal to prevent cross contamination of the floor. The Wound Care Nurse needs to ensure after removing dressings that they are placed in a closed container for disposal to prevent cross contamination. Review of the quarterly Skin Integrity Committee Minutes, 12/14/10 and 3/22/11 revealed that the committee discussed all unresolved and acquired decubitus. The 3/22/11 minutes indicated there had been no identified patterns found in acquired skin breakdown since the last quarterly meeting. However, the committee minutes were very brief in content and the details of discussions were not included in the minutes. There was no formalized 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. Not all of the Wound Care Nurses' pertinent communication with other disciplines was documented in the Integrated Progress Notes. The Facility's POI, Section M.1 Compliance Visit/Section and Recommendations, M.26.1, Outcome stated, "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." Action Steps stated, "Skin Integrity Nurse will electronically send a consultation report to the appropriate discipline." Review of the Facility's POI evidence validated compliance with the recommendation. Review of documentation, 10/27/10 through 3/3/11, contained copies of at least 85 e-mails sent to Occupational Therapist, Physical Therapist, Dietitian, Physician, nursing staff, and other disciplines regarding individuals' skin care, positioning, and dietary needs. It was evident in review of the e-mails that the other	

#	Provision	Assessment of Status	Compliance
		disciplines responded promptly to the Skin Integrity Nurse, usually within the same working day. It was positive to find this enhanced communication and collaboration between these disciplines, which was important to addressing individuals' needs and satisfying the recommendation. However, this important information was not included in Integrated Progress Notes in the individuals' official medical records. Thus, if only reviewing the Integrated Progress Notes for compliance with integrated collaboration between disciplines, all of this valuable information would not have been identified, making it appear there was no collaboration. The lack of the availability of the electronic communication in the medical records interferes with continuity of care because the purpose for having an official medical record is to have a central depository for all information pertaining to individuals' care that is available for all disciplines to use when making clinical decisions. While the use of electronic communication is a quick and efficient method of communication, the Facility needs to evaluate how electronic communication can be incorporated into individuals' official medical record. <u>Diabetic Services</u> The Facility had undertaken a number of initiatives to improve diabetic services. Staffing and Coordination: Since the last review the CNE had reassigned the nursing position of the Diabetic Educator Nurse to another nurse. The new Diabetic Educator Nurse began full-time responsibilities for the coordination of Diabetic Services in February 2011. The groundwork for surveillance and coordination of Diabetic Services that was established by the previous Diabetic Educator Nurse was continued with refinement and expansion of that role. Currently the Facility had 47 individuals diagnosed with Diabetes. In March 2011 the Diabetic Educator Nurse began coordination of services and care on a continual basis through the following activities: • Coordination of Diabetic Services: The Diabetic Educator Nurse attended daily Morning Infirmary Rounds. Problems related to health management (including diabetic management) of all individuals were summarized by the on-call Primary Care Provider. These reports became the focus for the educator to identify needs for the individuals with diabetes. The Diabetic Educator Nurse made rounds on those individuals who had experienced problems and they became the priority of the day to evaluate blood sugar history, insulin administration, dietary intake and possible identification of learning needs of the staff and/or individuals. • Daily Rounds: Diabetic Educator Nurse made visits to various apartments across campus daily to visit with staff and individuals diagnosed with diabetes to assess their progress, as well as to review pertinent health information. Developing trends were documented in the SOAP format in the Integrated Progress Notes and communicated to the dietitian, Nurse Case Manager, and Primary Care	

#	Provision	Assessment of Status	Compliance
		Provider, as indicated. • Monthly Summary: The Diabetic Educator Nurse copied all information related to finger stick blood glucose and insulin administration from the Medication Administration Records at least monthly. This data, as well as new orders related to diabetic management, were entered into a spreadsheet and made available to the Nurse Case Managers and Primary Care Providers. After review, if developing trends existed, the team communicated the findings through the Morning Rounds or via e-mail communication, followed by an entry in the Integrated Progress Notes. • Endocrinology visits: The Diabetic Educator Nurse accompanied all individuals on scheduled appointments to the Endocrinologist. The Diabetic Educator Nurse in preparation for individuals'clinic visits to the Endrocrinologist, reviewed of all previous Endocrinology recommendations and checked for completion and results. The Diabetic Educator Nurse prepared an informational packet containing the most recent lab results, radiology reports, consultation reports of recommended referrals (vision, cardiac, and others as indicated), medication list, physician annual summary, and spreadsheets of all blood glucose and insulin administration since the last appointment. On the day of the individual's scheduled appointment, the Diabetic Educator Nurse prepared a written and oral summary of progress, which was provided to the Endocrinologist. The Diabetic Educator Nurse clarified any information, answered questions, and provided follow-up for concerns that the specialist may have had. When the individuals returned to campus from appointments, communication of the recommendations from the Endocrinologist to the Primary Care Providers was provided in written form and placed in the informational packet. The Diabetic Educator Nurse communicated concerns or recommendations that needed immediate attention to the Nurse Case Manager sand Primary Care Providers. The Diabetic Educator Nurse explained this collaborative approach to the coordination of diabetic services had been most beneficial for individuals by helping stabilized their diabetic condition. The Diabetic Educator Nurse stated she served as the individuals' "voice" as an advocate for his/her care. According to the Diabetic Educator Nurse this means of diabetic care coordination had been regarded favorably by all members of the PST, as well as the Endocrinologists.	

#	Provision	Assessment of Status	Compliance
		Diabetic Supplies and Management and Prevention of Diabetic Emergencies: • Diabetic Emergency Supplies. As a result of a diabetic emergency involving an individual who was returning from an off-campus emergency appointment, the process for making diabetic supplies available was initiated. In collaboration with the Central Kitchen Director and Dietician as well as members of the team for that individual, plans were put in place for providing emergency diabetic snacks for all individuals who travel off campus. • DSSLC now has processes in place for the management of diabetic emergencies. Key information included: o Identification of the individual with diabetes: Color coded information sheets had been posted in all Home Shift Logs and Individual Notebooks which identify the individuals who reside in that home who have diabetes, care considerations, and management of diabetic emergencies. o Management of Diabetic Emergencies: Processes for emergency response during a diabetic emergency have been refined. Responsibilities have been outlined according to the level of care provider in order to increase everyone's understanding of their role in the emergency. o Emergency Supply Kits: DSSLC had emergency diabetic supply kits for individuals who frequent the common areas of the campus and for off campus trips. The Emergency Diabetic Supply Kits were sealed containers of pre-thickened orange juice, glucose gel, and a cup. These supply kits were distributed to the gymnasium, chapel, workshops, Life Skill Wellness programming and canteen (Wooden Nickel). Upon recognition of the signs and symptoms of low blood sugar, these kits provided the direct care professionals with pre-thickened orange juice, so that early intervention for hypoglycemic episodes was possible. In order to meet the needs of all individuals and reduce the possibility of aspiration, the team selected honey thickened orange juice as the standard for the kits. Replacement of the used kit was the responsibility of the Nursing Supervisors. The Diabetic Educator monitors the use and effectiveness of the emergency supply kits. o The Diabetic Supply Pack was a kit provide by Central Kitchen the morning of an individual's excursion and requested by any staff that completed a Community Activities Request Memo. The contents of this pack contained pre-thickened juice, as well as a protein source for further stabilization of the blood sugar.	

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		Diabetic Education: • Campus-wide training on the processes above were conducted the weeks of March 7 though 18, 2011. At the time of the review 502 care providers of all levels had received the in-service training related to diabetic emergency management. The training will be ongoing and the content was included in the New Employee Orientation. Future goals for Diabetic Education included: • Facilitation of a more comprehensive management of diabetic services through the coordination of communication between the primary care providers, nutritional support, diabetic educator, and consulting specialists (endocrinology, cardiology, renal, and vision). • Development and presentation of unit-based educational offerings for the direct care professionals and nursing staff regarding diabetic management. • Development of family education and support programs for the families of individuals who are diabetic. An example of the recently enhanced Diabetic Education and Management was best demonstrated through review of Individual #367's record. There was evidence that direct care professionals were provided additional Diabetic care training on 3/25/11. The Diabetic Educator Nurse developed a Diabetic Information Sheet unique to Individual #367's diabetic condition and placed it in the Me-Book (Individual Notebook) for quick reference by the direct care staff and any other staff who may need access to the information. The information sheet included information regarding how to response if Individual #367 should have an emergency related to hypoglycemia or hyperglycemia. The Diabetic Educator Nurse had worked collaboratively with the Dietitian and Endocrinologist and physician to manage Individual #367's diabetic condition by closely monitoring blood sugar level, dietary intake and adjustment to insulin regimen. There was documentation that Diabetic Educator accompanied Individual #367 on appointments to the Endocrinologist. Review of the record for the past three months indicated when Individual #367 experienced episodes of hypoglycemia or hyperglycemia that Individual #367 and/or direct care staff promptly notified the nursing staff, who responded promptly and intervened to stabilize his blood sugar level. Individual #367 had not had to be treated in the emergency room for hypoglycemia or hyperglycemia since November 2010. Prior to November 2010 Individual #367 had numerous visits annually to stabilize blood sugar levels. <u>Availability of Pertinent Medical Records</u>	

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		In general the active records were better organized and more accessible than at the last review. However, medical and health related information continued to be located in at least three separate sections of the record. Some individuals' records were contained in as many as five binders. The Annual Nursing Assessments continued to be located in the Program Records. This made locating all of the nursing documentation/records cumbersome and time consuming and could interfere with continuity of care when such information needs to be readily accessed. All of the nursing documentation needs to be contained in the medical chart for continuity in reviewing and using medical and health related information, e.g., Physician's Orders, Active Problem List, History and Physicals, lab and other diagnostic reports, consults, immunizations, integrated progress notes, seizure records, and other related documentation. Some of the documents were misfiled in the records. The Integrated Progress Notes continued to have blank spaces that were not correctly marked out. The Facility was in the process of revising the Abbreviation List. The Facility needs to ensure that the Abbreviation List includes all acronyms used as well as standard abbreviations. In general there had been improvement in nursing documentation. The Subjective, Objective, Analysis, and Plan (SOAP) method of charting was used consistently. The quality of the content for assessments, interventions and planning demonstrated improvement since the last review. The "P" portion of the note typically explained what was planned as opposed to simply stating "continue to monitor." The nursing staff were beginning to document the method temperatures were taken. There were fewer late entry notes. The legibility of the content of the notes, signatures, and titles showed little improvement since the last review. Dates of entries in the Integrated Progress Notes were not always in chronological order. The time and discipline writing the notes were not always present. Both maritime and military times were used. For continuity one or the other method of documenting time should be used consistently. Documentation errors typically had a straight line drawn through the entry but did not consistently contain the date, time, and initial of the nurses making the corrections as required. Documentation of oxygen saturation percentages did not consistently document whether they were measured on room air or with the use of oxygen. The Nursing Department needs to continue to improve all aspects of documentation. <u>Infection Control</u> The Communicable Diseases by Select Code Reports and Clients Testing Positive for Tuberculosis (TB) Reports were reported to the Department of Health as required. The Infection Control Department continued to list all infections including any occurrences from the list of reportable communicable diseases, such as Methicillin-resistant Staphyloccus Aureus (MRSA) Hepatitis A, B, and C, positive tuberculin skin test,	

#	Provision	Assessment of Status	Compliance
		Hemagglutinin Type 1 and Neuraminidase Type 1 (H1N11), Clostridium Difficile (C-Diff), and Sexually Transmitted Diseases (STDs). Lists of infections and reportable communicable diseases were provided in the document request. However, for the raw data to be meaningful for review they need to be analyzed and trended. The Infection Control Committee did report on infectious diseases for the last two calendar quarters of 2010. The raw data listed below for communicable diseases reported by Select Code reported, 9/1/10 through 2/28/11 could not be correlated with the data reported for the last two quarters of 2010. This data are reported as a benchmark for future compliance reviews: • MRSA – 23 cases • Vancomycin Resistant Enterococcus (VRE) – 3 • Aspiration Pneumonia – 36 cases • Conjunctivitis – 92 cases In addition to the problem focus analysis the Facility was completing on Aspiration Pneumonia, the Facility needs to conduct a problem focus analysis on the high incidence of conjunctivitis which is a contagious disease that is easily spread and requires meticulous hand washing and standard precautions to prevent its spread. The incidence of MRSA infections also needs examination. The Infection Control Nurse explained that infections/communicable diseases were reported in several ways: Twenty-four Hour Nursing Reports, Pharmacy's Drug Utilization of Antibiotics, Morning Rounds, and direct reports from nurses and other providers. This information was entered into the Infection Control Database. When the Monitoring Team asked how the reliability of the data was evaluated, the Infection Control Nurse said she did not reconcile the data. After our discussion, she provided the Monitoring Team with a plan for reconciling the infection data which included: • A sample of three or four individuals per week from the Morning Rounds. The report will be compared to both the 24 Hour Nursing Report and the Pharmacy's Drug Utilization of Antibiotics to ensure congruency of the information. • As needed/indicated the records will be reviewed to ensure that the documentation is congruent and appropriate. • The data will be collected for analysis and trending. The report of findings will be shared at the quarterly Infection Control Committee Meetings or as needed with the appropriate disciplines. While this was a positive step toward reconciling infectious data reporting, the Infection Control Nurse needs assistance in establishing a formalized method for checking the reliability of data collected. Establishing an appropriate method to guide the process for	

#	Provision	Assessment of Status	Compliance
		ensuring the accuracy and reliability of the data is necessary. Without reliability, the analysis and interpretation of the infectious data could easily be skewed and trends not accurately identified. Additional concerns were identified in the manner in which the Infection Control Committee Meeting Minutes, 7/1/10 through 9/30/10 and 10/1/10 through 12/31/10, described the incidences of infectious diseases: • The reporting period 7/1/1 through 9/30/10, stated the following: o *Respiratory infections: Increased sharply in August – 15 were bronchitis, 10 were sinusitis, rhinitis or pharyngitis; the rest were nonspecific.* o *Conjunctivitis: Dropped – some frequent infections were put on prophylactics.* o *Pneumonia: has remained steady since April with a bump up in September - approx. ¼ were candidiasis possible after antibiotics in August for URI's.* o *UTIs:* (Urinary Tract Infections) *Slight increase in heat of summer (dehydrations?).* o *SSTI:* (Skin and Soft Tissue Infection) *Surprisingly dropped thru summer with a bump possibly after antibiotic use in August for URI's.* o *C-diff:* (Clostridium Difficile) *Remains low.* o *VRE:* (Vancomycin-Resistant Enterococcus) *Remains low.* o *MRSA:* (Methicillin-Resistant Staphyloccus Aureus) *All were cases of colonization – except one reported blood infection, but that was a probable contaminant.* Discussion of the meeting included: o Pneumonia – The Medical Director asked about breakdown of Aspiration Pneumonia vs. other types of pneumonia. It was reported [by whom was not indicated] that they were broken down in the detailed report. o UTIs - The Medical Director asked about running reports for men vs. women. It was reported that 17 of 45 infections were men and 18 were e-coli infections. Who the 18 related to was not identified. • The reporting period 10/1/10 through 12/31/10, stated the following information: o *Respiratory/pneumonia had an expected increase in October, which may have lead to the increase in Skin Infections – fungus accounted for approximately 1/3.* o *UTIs had a slight hiccup in November. IC has begun notifying RN Case Managers of repeat infections (over 3 in a year). Of the MDROs* (Multi Drug-Resistant Organisms), *only MRSA saw an increase, most likely due to hospital screenings with the increase in pneumonia in October. Most*	

#	Provision	Assessment of Status	Compliance
		cases are not infections, but colonization of nares. Discussion of the meeting included: o Run reports on UTI and SSTI by home – present this with teaching tools to unit directors at the Incident Management Review Team Meeting on 1/26/11. o Add Aspiration Pneumonia to data review and track precipitating factors. Aspiration Pneumonia reviewed for Calendar Year 2010 showed a downward trend. o Discussed new efforts to further reduce [infections] including Aspiration Pneumonia/Enteral evaluations. o Prophylactic antibiotic use for UTIs may contribute to antibiotic resistance. o Add Pseudomonas as an MDRO to track. o MRSA increase was followed by a decrease – no action required. While it was positive to find that the committee made efforts to improve reporting, analyzing, and trending; the manner in which infection data were presented was inadequate to derive a meaningful analysis from which to determine trends and make sound clinical decisions. The reporting of infection data in terms of "drops, hiccups, bumps up and/or down, slight increases and/or decreases, seems high" was meaningless unless there were quantitative and qualitative data represented. Neither did presumption of causative and/or possible contributing factors provide meaningful data on which to make sound clinical decisions. If there were presumptions made as to the cause or possible contributing factors, it was the responsibility of the Infection Control Nurse to investigate further to validate whether these suppositions were factual or not before reporting. The Facility needs a standardized methodology for calculating the rates of infections. Rates should be calculated for each living area and the Infirmary as well as for the whole facility. Rates should also include nosocomial rates According to the Association for Professionals in Infection Control and Epidemiology, Inc. (APIC), "infection rates should be calculated monthly, quarterly, and annually. Analysis of absolute numbers of infections can be misleading. Health Associated Infections calculated rates provide the most accurate information. Rates are generally calculated by using 100 resident-days as the denominator. A standard infection report form facilitates reporting of surveillance information. Tables, graphs, and charts may be used and facilitate education of staff. Surveillance data should be used for planning infection control efforts, detecting epidemics, directing continuing education, and identifying individual resident problems for intervention. In addition to the collection of baseline infection rates, the Infection Control program should perform problem focus studies. Example, special studies for the evaluation of UTIs in catheterized residents, a study of the occurrence of influenza in	

#	Provision	Assessment of Status	Compliance
		vaccinated versus unvaccinated residents, or the prevalence of pressure ulcers. In addition to the above outcome measures, surveillance should also include analysis of process measures relevant to infection control. Examples include monitoring hand hygiene compliance, observation of aseptic techniques, and measuring influenza vaccination rates." The Nursing Department should provide the Infection Control Nurse with the assistance of an Infection Control expert or formalized training in Infection Prevention and Control for Long-Term Care Facilities. The Monitoring Team was unable to find the 1/26/11 Incident Management Review Team Meeting Minutes. The Incident Management Review Team Meeting Minutes, of 2/23/11 were reviewed and contained an Aspiration Pneumonia Report for five individuals that reviewed for Aspiration Pneumonia precipitating factors. Review of the precipitating factors for Aspiration Pneumonia for the five individuals reviewed were inadequate for gaining a thorough understanding as to what factors that may have contributed to Aspiration Pneumonia. Neither were preventative measures discussed by the team. The precipitating factors contributing to Aspiration Pneumonia the team identified for each of the five individuals included: • *Transported to hospital on 2/4/11.* • *PNMP to be checked for use of wedge on bathing table.* • *Emesis and he has HOBE* (Head of Bed Elevation). *In bed when it occurred.* • *He went out on the 2/19/11 due to having several episodes of emesis.* • *Recently had a swallow study and liquids was changed to thicken. She has no HOBE. May need a GI* (Gastrointestinal) *consult.* The Facility's Incident Management Review Team needs to thoroughly explore precipitating factors that contribute to Aspiration Pneumonia and make substantive recommendations for prevention. In Addition, it was noted that the Infection Control Nurse was listed as a guest to the meeting. According to the Facility's POI the Infection Control Nurse was responsible for presenting the team with information correlating the incidents of Aspiration Pneumonia with the precipitating factors and presenting this information monthly at Incident Management Review Team Meetings. The Infection Control Nurse needs to become a permanent member to the Incident Management Review Team. Review of the Aspiration Report for January, February, and March 2011 was difficult to interpret. Of the precipitating factors listed; only 11 of the 15 cases (73%) had precipitating factors listed. Even so, the precipitating factors were inadequate to understand what may have contributed to individuals' Aspiration Pneumonia. As stated earlier, all possible precipitating factors must be explored in depth and expressed in a meaningful way in order to make appropriate clinical decisions to prevent future	

#	Provision	Assessment of Status	Compliance
		occurrence of Aspiration Pneumonia. In addition to addressing precipitating factors unique to individuals, the Aspiration Reports provides data to analyze and track trends related to precipitating factors that may have systemic ramifications. Additionally, according to policy, each case of Aspiration Pneumonia was to have precipitating factors examined. The Aspiration Pneumonia Reports should be accurate, factual, and presented clearly so they can be readily understood. The Aspiration Report contained the following information:	

Month	New	Hospital	Precipitating factors and comments
January	7	6	One treated on campus, one aspirated in the hospital
February	6	6	Four emesis; two no triggers noted
March	3	3	Two emesis; one GERD (as of 3/15/11)

It was positive to find Aspiration Pneumonia Graphs and Tabular Charts comparing the number of Aspiration Pneumonias that occurred in 2010 to 2011 to date (January, February, and March), which showed a steady decline in the incidents of Aspiration Pneumonia. The graphs represented raw numbers of occurrence. There was no narrative explaining the Facility's rationale for the perceived decrease. The CNE theorized that the use of suction toothbrushes had helped to decrease the incidents. Since January 2011 the Facility had implemented and trained staff on the At Risk Individual Policy and the Aspiration Pneumonia Evaluation, and all nursing staff were re-trained in the Aspiration Pneumonia Clinical Protocol and Vomiting Protocol. Call the Nurse training was provided to the direct care professionals with Call the Nurse flyers distributed to all living units, all direct care professionals were trained on Signs and Symptoms to Report to Nurses to Prevent Aspiration Pneumonia, and Aspiration Pneumonia Trigger Data Sheets were implemented for individuals at risk for Aspiration Pneumonia. It plausible that these efforts were beginning to have an impact in reducing the incidents of Aspiration Pneumonia. However, not enough data had been collected and analyzed to have confidence in the decline on incidents of Aspiration Pneumonia. The tables are illustrated below:

Aspiration Pneumonia Graphs for Calendar Year 2010 and 2011

2010	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
# cases	7	8	21	8	9	6	7	11	7	4	5	6
Quarter		Qt 1			Qt 2			Qt 3			Qt 4	
Quarterly Average		12.00			7.67			8.33			5.00	

2011	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
# cases	7	6	3									

#	Provision	Assessment of Status	Compliance

Quarter		Qt 1			Qt 2			Qt 3			Qt 4		
Quarterly Average		4.33											

According to the Facility's POI Report, the Infection Control Nurse taught hand washing skills, standard precautions, and signs and symptoms of infectious disease in New Employee Orientation. This was validated by the Competency Training and Development Sign-In Sheets for 3/2/11 supplied in the Facility's evidence books. The Monitoring Team requested a copy of the Competency Training and Development Report to review the status for all employees' current Infection Control training but it was not available for review. Therefore, the status for Infection Control training for all staff could not be validated.

The Infection Control Committee Minutes for the reporting period 7/1/10 through 9/30/10 indicated the Quality Assurance Nurses were responsible for monitoring hand washing. According to the report, some of the Quality Assurance data was missing; QA nurses had not submitted all required data. Monitoring hand washing is a requirement of the Health Care Guidelines (HCG). For this reporting period the Facility failed to meet compliance with the requirement. The findings are listed below as a benchmark for future compliance reviews:

Hand Washing Monitoring Data from 7/1/10 through 9/30/10

Discipline	# Monitored	# Adequate	Percentage
Nursing	20	18	90%
Direct Care Professional	237	220	93%
Respiratory Therapy	0		
Doctors	5	5	100%
Total	262	243	93%

The Infection Control Committee Minutes during the reporting period for 10/1/10 through 12/31/10 indicated that the monitoring data for hand washing compliance was incomplete due to the failure of the Infection Control Nurse to receive all the data from the Quality Assurance Nurses. Only three reports were received from the Quality Assurance Nurses. For this reporting period the Facility failed to meet compliance with the requirement. Sample completed Hand Washing Monitoring Tools were submitted in the document request but they were not adequate to evaluate the status of compliance

#	Provision	Assessment of Status	Compliance
		with the HCGs. Hand washing is one of the most important infection control measures in long term care facilities to prevent the spread of infection and must be monitored routinely. The Facility needs to ensure that hand washing is monitored routinely, data analyzed, and trends reported. Corrective action, both systemic and individual, needs to be put in place when there are errors in following proper hand washing at all times to prevent the spread of infection as well as for compliance with the Settlement Agreement and Health Care Guidelines. The last two quarterly Infection Control Committee Meeting Minutes failed to report monitoring data for Standard Precautions and Environmental Surveillance. Sample completed Standard Precautions and Environmental Surveillance Monitoring Tools were submitted in the document request but were not adequate to evaluate the status of compliance with the Settlement Agreement. Standard Precautions and Environmental Surveillance are equally as important to monitor, analyze and tract as proper hand washing techniques in preventing the spread of infections. Monitoring and analyzing Standard Precautions and Environmental Surveillance were also HCG requirements of the Settlement Agreement. Therefore compliance was not met for monitoring and analyzing Standard Precautions and Environmental Surveillance. The Facility needs to ensure that Standard Precautions and Environmental Surveillance are monitored routinely, data analyzed and trends reported. Corrective action, both systemic and individual, need to be put in place when there are errors in following proper hand washing at all times to prevent the spread of infection as well as for compliance with the Settlement Agreement and Health Care Guidelines. At the time of the review the Infection Control Nurse reported that 95% of the individuals were current with Tuberculosis Screenings. A few individuals were hospitalized or refused screening, and some had chest x-rays that had not been read. She reported that 74% of the employees were current in Tuberculosis Screenings. She said, "some were still "trickling in." As was reported in the last review the Facility had difficulty with employees complying with Tuberculosis Screening. According to the 2008 Centers for Disease Control and Prevention reported that Texas ranks as one of the four top leading states in the nation for the incidents of Tuberculosis. The Facility needs to aggressively insist that employees complete Tuberculosis Screenings according to Facility policy. At the time of the review the Infection Control Nurse reported that 98% of the individuals received the influenza vaccine for the 2010 flu season. No rationale was provided for the 2% who did not receive the influenza vaccine. She reported that only 30% of the employees received the influenza vaccine for the 2010 season flu. The Facility should strongly encourage employees to receive their annual influenza vaccine.	

#	Provision	Assessment of Status	Compliance
		It was positive to find that since the last review the Immunization Database was updated to track and flag due dates for immunizations. Review of Nursing Annual and Quarterly Nursing Assessment did not consistently document the status of MMR, Hepatitis A and B, Varicella, and Zoster vaccines. Either documentation of prior immunizations, history of these diseases, or results of titers, if drawn, needs to be documented; otherwise individuals need to be revaccinated according to the Centers for Disease Control and Prevention guidelines. In addition, the status of individuals for pneumococcal vaccine or re-vaccination needs to be reviewed. The Infection Control Nurse in collaboration with medical and nursing staff needs to evaluate individuals' immunization status to ensure they are current with the Centers for Disease Control and Prevention's immunization guidelines. The Infection Control Program continued the use of Antibiograms. They are updated quarterly from the State Laboratory. Upon receipt they were printed and distributed to all physicians and nurse practitioners. The Infection Control Nurse maintained a current Drug Utilization Report for Antibiotics. From the interview with the Infection Control Nurse it was not clear how she interfaced with the Pharmacy and physicians in regard to the use of antibiotics. Because of the increasing problem that antibiotic-resistant bacteria pose in treating individuals, the Infection Control Nurse should collaborate with the Pharmacy and physicians in reviewing the use of antibiotics and monitoring for appropriateness. The Infection Control Nurse should monitor antibiotic susceptibility results from cultures to detect clinical significant antibiotic-resistant bacteria, such as MRSA, VRE, and Pseudomonas aeroginosa. Changes in antibiotic-susceptibly trends should be communicated to appropriate clinical staff and Infection Control Committee. 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. Examples: Individual #185 was suspected to be contagious for Cytomegalovirus (CMV) but did not have toxoplamosis. Her Annual Physician's Summary listed "history of CMV versus toxoplamosis" for many years. However, the physician requested the Infection Control Nurse to in-service the home staff on CMV. The Infection Control Nurse provided Individual #185's staff in-service training and a plan for managing care. There were numerous e-mails sent by the Infection Control Nurse to the nursing staff and other discipline regarding individuals who had repeated infections of various types, e.g., UTIs, pneumonia, and conjunctivitis. It was positive that the Infection Control Nurse communicated and collaborated with other staff. While communication electronically is a quick and efficient means of communication, it needs to be included in the individuals' official medical records.	

#	Provision	Assessment of Status	Compliance
		The scope of the Infection Control Program was comprehensive and multifaceted and went beyond clinical services to include infection control issues in other service areas such as food services, maintenance, housekeeping, environmental control, laundry services, waste management, resident activities, safety, emergency preparedness and employee health to list a few. In many of the State Supported Living Centers their Infection Control Programs have two Infection Control Nurses and/or an Assistant Infection Control Nurse. Considering the size of DSSLC, the Facility and Nursing Department should consider assigning another RN to the Infection Control Program to ensure that all aspects/requirements of the Infection Control Program are effectively and efficiently carried out.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	Since the last tour the Nurse Case Manager Supervisor had revised the training material for the Comprehensive Nursing Assessment to provide more inclusive definitions and explanations on how to complete each section of the assessment. On 1/20/11 she began retraining the Nurse Case Managers in order to improve the content and quality of the Annual and Quarterly Comprehensive Nursing Assessments. She explained that she was individually training each Nurse Case Manager. According to Nursing POI, the Nurse Case Manager Supervisor began utilizing the quarterly nursing assessment to train the Nurse Case Managers how to evaluate the effectiveness of Health Maintenance Plans. The CNE, NOO and Nurse Case Manager all agreed they were not in compliance with this provision but were diligently striving to meet the requirements of the Settlement Agreement and Health Care Guidelines. The training conducted by the Nurse Case Manager Supervisor should continue to include teaching Nurse Case Managers how to apply critical thinking when analyzing clinical data, covering how to write the findings of the analyses, and adequately measuring the nurses' competency in producing quality nursing assessments and plans of intervention. The State was in the process of implementing Physical Assessment Training for all RNs. When the State Office rolls out the Physical Assessment Training, the Nursing Department needs to ensure that all Nurse Managers and Nurse Case Managers receive the competency-based training on Physical Assessment. The Nurse Case Managers were consistently using the Comprehensive Nursing Assessment form for completing annual and quarterly nursing assessments. Through the use of this form, the quality and content of the assessments were continuing to show steady improvement; however; there were areas still in need of improvement. Nursing assessments are a dynamic, ongoing, and continuous process of collecting. evaluating, and communicating health information regarding each individual's needs. Nursing assessments are the foundation from which actual health care problems and high-risk potential problems/nursing diagnoses are identified. It is from this information that plans of care are developed and implemented to address, prevent, and/or resolve problems. The assessments summarize pertinent health data from which change can be	Noncompliance

#	Provision	Assessment of Status	Compliance
		measured and goal achievement measured. Therefore, health care plans, whether acute or long term, must be based on complete and accurate nursing assessments. The Annual and Quarterly Comprehensive Nursing Assessments were reviewed for the following 18 Individuals: #367, #12, #119, #238, #546, #487, #638, #175, #569, #776, #183, 605, #123, #464, #620, #703, #108, and #520. Review found 18 of the 18 (100%) individuals' Annual and Quarterly Nursing Assessments were completed by RN Case Managers according to their Personal Support Plan Schedule. The Braden Scale to rate skin integrity risk assessments was completed for 18 of the 18 (100%) individuals' Annual and Quarterly Comprehensive Nursing Assessments. The 18 individuals' Annual and Quarterly Nursing Assessments reviewed for the last six months were completed on the revised Comprehensive Nursing Assessment form. Nursing assessments completed on the Comprehensive Nursing Assessment form contained more complete assessment information: • All Sections on the Comprehensive Nursing Assessment Sections showed significant improvement since the last review. When comparing the content from quarter to quarter the improvement was impressive. It was apparent that considerable effort had been put forth in making the improvements. Some Nurse Case Managers demonstrated more competencies in completing the assessment than others. The most significant improvement was in the Sections I through IX. Although Section X through XI showed improvement in the amount of data collected, information was not always summarized succinctly enough to identify individuals' health status progress toward their established goals and objectives related to their specific problems and plans of care. The effectiveness of the plans of intervention was not consistently addressed. The Nurse Case Managers were working toward compliance and beginning to understand how to analyze raw clinical data and apply it to the individuals' established goals and objectives by describing each identified problems in the Nursing Summaries related to individuals' course of care, treatments, medications, and health events that occurred over the past quarter and/or year. The assessments and summaries in Sections I through IX often identified issues that were not consistently included in Sections XI of the Nursing Summary. • The Nurse Case Managers completing the assessment consistently signed the completed Comprehensive Nursing Assessments but the accompanying dates were not consistently included. Occasionally the boxes indicating that the Qualified Mental Retardation Professionals (QMRPs) and Personal Support Team Members were notified of the completed assessments were not marked. Both of	

#	Provision	Assessment of Status	Compliance
		these items showed significant improvement from the last review. • Sections X of Nursing Problems and Diagnoses did not consistently contain nursing problems written in the North America Nursing Diagnosis Association (NANDA) format. Nurse Case Managers were including nursing problems/diagnoses and plans of intervention related to individuals' risk scores. They were beginning to exercise clinical judgment to include nursing problems/diagnoses for stable but chronic conditions listed on the Medical Active Problem List for which they were receiving medical interventions that required nursing assessments/monitoring and interventions in order to ensure that individuals remain stable and/or to identify regression in health status. Examples of findings from review of the Annual and Quarterly Comprehensive Nursing Assessments are listed below: • Individual #123's Quarterly Comprehensive Nursing Assessment was completed on 2/22/11. Sections I through IX were completed adequately. Section X listed Nursing Problems as Constipation and Weight. The NANDA nursing diagnoses were not used. Section XI of the Nursing Summary contained raw data listing dates of problems and clinic visits. The summary statement described Individual #123 as "a pleasant woman" and described her daily activities. The summary failed to analyze the raw data and state Individual #123's health status regarding the constipation and weight problems, or whether she was improving maintaining or regressing toward established goals and objectives set forth in her Health Maintenance Plans. Neither was her progress compared to the previous quarter or annual assessments. Individual #123's Self Administration of Medication progress was not addressed. The box for notifying the Qualified Mental Retardation Professional and other relevant PST was not marked. • Individual #183's Annual Comprehensive Nursing Assessment was completed on 1/13/11. Sections I through IX were completed adequately. Risk factors had not been updated since 6/8/10. At that time they included: Medium risk for: Seizures, Urinary Tract Infection, Physical Aggression, and Psychological. Section X listed Nursing Problems as: Falls, Urinary Tract Infection, Seizure, Psychotropic Medication Side Effects, Oral Hygiene Deficit, and Pain. Individual #183 had HMPs developed and implemented for each of the identified nursing problems. Section X of the Nursing Summary consisted of three pages listing every physician's order, every order for change in psychotropic medications, dental visit, and nurses' notes for the past year. These listings were not necessary; they were raw data that could be read in the record. The Nurse Case Manager's time could have been better spent analyzing and summarizing the clinical data. The dates and number of falls experienced during the year were listed as were the dates and number of seizures. It was positive to find that	

#	Provision	Assessment of Status	Compliance
		information regarding psychotropic medications was mentioned but the data only addressed what Individual #183 was taking, changes in medication, reason for the medication, and the MOSES and DISCUS scored. Oral Hygiene Deficit information included the date she was diagnosed with Sjogren's disease and that she had poor oral hygiene. Pain was described as related to rheumatoid arthritis, how she manifested pain, and that she was treated with Tylenol and Vicodin for pain through out the year. The Nurse Case Manager failed to analyze the raw clinical data and apply it to Individual #183's health status related to each of the identified nursing problems, and failed to describe the progress made toward established goals in her Health Maintenance Plans, e.g., whether she was progressing, maintaining or regressing. Neither was her progress compared to the previous quarterly and annual assessments. Individual #183's Self Administration of Medication progress was not addressed. • Individual #367's Annual Comprehensive Nursing Assessment was completed on 1/11/11. Individual #367's assessment for Section I through IX were adequately completed except for: In Section IV for History, Functional and Psychosocial his sleep patterns were not marked as having been assessed. Pain was not assessed. Individual has a history of pain in his foot and in his ribs. The summary did not include that he was diagnosed on 11/15/10 with a healing fracture of the transverse processes of L2 and L4. The Nursing Summary did not mention the fracture of the transverse processes of L2 and L4 or the status of healing and level of pain that may have been associated with the fracture mentioned in Section XI of the Nursing Summary. Individual #367's Integrated Risk Rating assessment and a Risk Action Plan were completed 1/26/11. Individual #367 was rated at high risk for: Diabetes and Fractures; rated at medium risk for: Circulatory Challenging Behaviors and Dental. All other risk factors were rated as low. Nursing problems/diagnoses were listed as: Potential for alteration in skin integrity and Diabetes with an accompanying HMP for both problems. He was rated at high risk for fractures. In Section IV for History, Functional and Psychosocial his summary of fracture history stated that Individual #367 had an open reduction internal fixation of his left tibial shaft with an intramedullary rod on 4/8/10; fracture of the right proximal phalanx in 9/1998; fracture of right tibia and fibula in 5/2007; and the recent fracture of the transverse processes of L2 and L4. Individual #367 should have had the nursing problem/diagnosis for fracture listed and a HMP to aid in the prevention of future fracture. Additionally, because Individual #367 was rated at medium risk for Challenging Behaviors which may contribute to an increased potential for further fracture, the Nurse Case Manager should collaborate with the Personal Support Team to develop a collaborative plan of intervention. Section XI for Nursing Summary contained raw data regarding problems for the quarter listing clinic appointments and episodes of vomiting and a general review of	

#	Provision	Assessment of Status	Compliance
		HMPs for skin Integrity and Diabetes. It contained raw data related to episodes of skin infections and treatments and the number of hypoglycemic and hyperglycemic episodes. The summary stated the individual had been treated twice that year for in the emergency room for hypoglycemic and hyperglycemic episodes but did not explain if this was an increase or decrease of hypoglycemic and hyperglycemic episodes which required treatment in the emergence room. Neither did the summary describe the progress made toward established goals in his Health Maintenance Plans, whether he was progressing, maintaining or regressing. Nor was his progress compared from the previous quarterly or annual assessments. Individual #367's progress toward Self Administration of Medication progress was addressed. The block indicating that the assessment had been provided to the QMRP was not marked. • Individual #283's Quarterly Comprehensive Nursing Assessment was completed on 1/20/11. Section VII for Infection and Immunization, of measles, mumps, rubella vaccination or immunity status was not marked. Section VII for Physical Assessment, for Skin and Nails was marked clean and dry. The Musculoskeletal system was marked for no abnormal findings. Under the Section IV for History, Functional and Psychosocial the summary reported that Individual #283 wore molded therapeutic shoes to accommodate severe pronation and mid foot aqanentous collapse of feet; because ankles and feet are part of the musculoskeletal system, that item should not have been marked as having no abnormal findings. There was a note to "see consult" but what consult and where to locate it was not described in the summary. Individual #283 had been treated for tinea pedis on the left foot but there was no mention of this in the summary. According to the Health Status Review, Individual #283 was rated at high risk for: Weight Gain and Weight Loss and at medium risk for polypharmacy. Nursing problems/ diagnoses included: Risk for Impaired Skin Integrity, Risk for Infections, and Impaired Bone formation related to Osteopenia. Individual #283 had HMPs for: Weight-Over, Skin Integrity, Hypothermia, and Osteopenia/osteoporosis. Individual #283 was rated at high risk for polypharmacy and was receiving Valproic Acid, risperidone, clonazepam, Benztropine, and sertraline. The Nurse Case Manager should have established a Psychotropic HMP in collaboration with the Personal Behavior Support Team. The Nurse Case Manager failed to analyze the raw clinical data and apply it to Individual #283's health status related to each of the identified nursing problems, and to describe the progress made toward established goals in her Health Maintenance Plans, as to whether she was progressing, maintaining or regressing. Neither was her progress compared from to the previous quarter or annual assessments. • Individual #520's Quarterly Comprehensive Nursing Assessment was completed on 1/20/11. Sections VII, Infection and Immunization, the measles, mumps,	

#	Provision	Assessment of Status	Compliance
		rubella, hepatitis A and B and Varicella vaccinations or immunity status were not marked. Otherwise Sections I through IX were relatively completed. Individual #520 had nursing problems/diagnoses listed for: Risk of Impaired Skin Integrity, Potential for Pain Related to Degenerative Joint Disease, Alteration in Thought Process Related to Alzheimer Disease, and Potential for Altered Protection Related to PICA. Section XI for the Nursing Summary described the medication Individual #520 was taking for Alzheimer's Disease and stated, "Some days are better than others." It described the assistance he required for activities of daily living, but failed to describe the progress made toward established goals in his Health Maintenance Plans, or whether he was progressing, maintaining or regressing. Neither was his progress compared to the previous quarter or annual assessments, particularly as related to the progression of the Alzheimer Disease. His ability to perform the Self Administration of Medication program had declined but the assessment did not state how much it had declined and over what period the decline had occurred. Nor were plans discussed regarding the decline with the PST in order to revise the program to a level he might be able to perform. • Individual #119 was admitted to DSSLC on 10/27/10. His Admission Comprehensive Nursing Assessment was completed 11/10/10, within the 30 day requirement for admission. The assessment was completed appropriately for a new admission. Individual #119 had nursing problems/diagnoses listed for: Asthma, Constipation, Diabetes, Hypertension, Seizures, Tardive Dyskinesia, and Wound and Lacerations. HMPs were not available for review. Section XI for Nursing Summary gave a general description of adjustment since admission. He was at level three for Self Administration of Medication. Immunizations for Tetanus,/Diphtheria, Influenza Vaccine and Tuberculosis Skin Test were given. The result of the Tuberculosis Skin Test was not recorded. The Hepatitis B series was stared. The immunization status of Varicella was not documented. • Individual #12 was admitted to DSSLC on 12/8/10. His Admission Comprehensive Nursing Assessment was completed 1/6/11, within the 30 day requirement for admission. Individual #12's risk ratings were medium for: Hypertension, Asthma, and Weight Over. Individual #12's nursing problems/diagnoses included: Skin Integrity related to Chronic Self Abusive Behavior, Weight-Over. He had HMPs for: Alteration in Skin Integrity Related to Irritation or Injury and Weight-Over. There were no HMPs for Hypertension, Asthma or Psychotropic Medications. Individual #12 was prescribed Thorazine and Benadryl for behavioral/psychiatric purposes and Nebivolod for Hypertension. As a new admission it was important to monitor these medications, hence the Nurse Case Manager should have established HMPs for Psychotropic Medication and Hypertension.	

#	Provision	Assessment of Status	Compliance
		• Individual#620's Annual Comprehensive Nursing Assessment was completed on 2/22/11. Individual #620's assessment was thorough and complete in all sections. Individual #620's nursing problems/diagnoses included: Seizures, Constipation, Weigh-Over, Potential for Alteration in Skin Integrity, Anemia, Gastritis – Helibacter Pylori, and Oral hygiene Deficit. Skin Integrity related to Chronic Self Abusive Behavior, Weight-Over. Section XI for the Nursing Summary the Nurse Case Manager was successful in analyzing raw clinical data and described Individual #620's progress toward established goals and objectives set forth in the HMPs. The summary stated: o *Seizures – [She]remains seizure free this past year. Will continue with current medications. Is to follow-up with Neuro Clinic in April 2011. Will continue to monitor Mysoline levels every April and October. Levels have remained within normal range over the past year. Stable over past year.* o *Constipation – [She] averaged 2-4 prn suppositories per month over the past year. Has had recent increase in Dulcolax supp. In this last 4th quarter. Recently regressed due to requiring more prn suppositories. Will closely monitor BMs daily and consult with Medical Provider.* o *Weight-Over – [She] has regressed over past year …7 lbs above AWR prior year. Currently 12.4 lbs above AWR. TSH level within normal range. 2/14/11 diet change recently made to decrease calories. Will closely monitor weight and confer with IDT members as needed. Potential Alteration in Skin Integrity – [She] has continued to have multiple superficial scratches over past year. [She] is at risk for injuries due to limited space when she self-propels her wheelchair throughout the day at home. PST members met this past year to discuss injuries to right hand-middle knuckle and how to eliminate/decrease injuries. QMRP visited 2 new homes for this past year for better mobility placement and did not find proper environment. Team recommended applying Liquid Bandage (new /skin) prn when superficial injuries occur. This has been beneficial as [she] removes all band aides and gloves that are applied. Stable.* o *Anemia – [She] has regressed due to new diagnosis of iron deficiency anemia. Recent Pelvic Sonogram showed a uterine fibroid 2/6 x 2/9 cm which could attribute to her heavy menses. She is currently awaiting for a hysteroscopy D and C to be scheduled. If menorrhagia continues after these procedures then an endometrial oblation or hysterectomy will be scheduled. Will continue e to monitor CBCs.* o *Gastritis-Helibacter Pylori – Recently regressed due to newly diagnosed H. Pylori 2l14/11. Is currently receiving PrevPack BID x 14 days for treatment of H. Pylori (ordered 2/22/11). Chronic gastritis is being treated with Prilosec which as ordered 2/22/11. Will continue to follow and monitor.*	

#	Provision	Assessment of Status	Compliance
		o *Oral Hygiene Deficit – Regressed as Nov 2010 dental exam reported good oral hygiene …Feb 2010 exam revealed poor oral hygiene and soft tissue. Will continue to receive oral care/tooth brushing TID. Will follow-up and confirm that [she] attends all scheduled dental visits.* o *It is recommended that [she] continue to receive Level I SAM prerequisite training.*	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	The Monitoring Team reviewed over 45 HMPs and ACPs related to the 18 individuals reviewed. The Nurse Case Managers provided an appropriate baseline status of individuals' health status and reasonably appropriate goals. However, it was rare to find that the content of the HMPs and ACPs were individualized. HMPs and ACPs need to be more than a perfunctory paper exercise. The purpose of the plan is to identify specific interventions for each identified nursing problem/diagnoses to improve, alleviate, or maintain health status. For the plans to be meaningful and beneficial Nurse Case Managers need to carefully review the content contained in the Health Care Protocols for Developmental Disability Nurses and use them as a reference guide. This was discussed with the CNE, NOO, and Nurse Case Manager Supervisor. They agreed and recognized that compliance was not met with this provision of the Settlement Agreement. They plan to continue to re-train and reinforce the need to individualize the care plans to meet individuals' unique health care needs. The HMPs were rarely noted as being reviewed and/or revised at the time of the Quarterly Comprehensive Nursing Assessments. Another issue identified as a problem with the care plans was the Nurse Case Managers maintained HMPs and ACPs in a notebook on each Unit and the plans may have been modified in their notebooks but not in the official medical record. There was evidence shown to the Monitoring Team that provided validation of direct care professionals' training on the HMPs and ACPs. Records were kept in separate binders on the Units but not in individuals' official medical records. The Nursing Department needs to ensure: o HMPs and ACPs are individualized beyond the baseline data and goals. o That the current operating HMPs and ACPs are in the individuals' official medical record. o When HMPs and ACPs are established that documentation is written on the HMPs and ACPs, and in the Integrated Progress Notes validating that direct care professionals were trained. o When the Quarterly Comprehensive Nursing Assessment are completed the Nurse Care Managers must review and revise the HMPs and ACPs, and then document that it was done on the HMPs and ACPs. Some examples of finding from review of HMP and ACPs are listed below: • Individual #123's Health Maintenance Plans (HMP) for Weight-Over and Constipation, established 6/14/10 were not noted as reviewed/revised at the time	Noncompliance

#	Provision	Assessment of Status	Compliance
		of the Quarterly Comprehensive Nursing Assessment, 2/22/11. HMPs were copied directly from the stock care plans, except for the baseline data and goals. There was documentation that direct care professionals were trained in the HMP for Constipation. Acute Care Plan (ACP) for Otitis External, 3/23/11, was not individualized except for the baseline data and goal. There was no documentation on the ACP that the direct care professionals were trained. There was no documentation in the Integrated Progress Notes that an ACP had been established and direct care professionals trained. The ACP for Urinary Tract Infection, 3/16/11, was not individualized except for the baseline data and goal. The Integrated Progress Notes for 3/16/11 did document instructions to the direct care staff regarding the side effects of the prescribed antibiotics and to encourage increased fluids. There was no documentation other than an ACP for Urinary Tract Infection. The ACP did not include a resolution note, which should have been resolved and documented by the date of the Monitoring Team review. • Individual #367 had HMPs established for Diabetes Mellitus, Insulin Dependent and Risk for Impaired Skin Integrity Related to Minor Injuries, Irritation, and Rashes on 1/26/11. Except for the baseline data and goal the HMPs were not individualized and were copied directly from the stock plans. There was documentation that direct care professionals were trained on the Diabetic HMP but not for the Skin Integrity Related to Minor Injuries, Irritation, and Rashes HMP. • Individual #283 had HMPs for: Weight-Over, Skin Integrity, Hypothermia, and Osteopenia/osteoporosis. Individual #283 was rated at high risk for polypharmacy and was receiving Valproic Acid, risperidone, clonazepam, Benztropine, and sertraline. The Nurse Case Manager should have established a Psychotropic HMP in collaboration with the Personal Behavior Support Team. Review of the Hypothermia HMP indicated that temperatures would be taken each shift axillary and if below 96 degrees notify the physician. Discussed the Hypothermia HMP with the Nurse Case Manager Supervisor, and asked if taking her temperature was realistic and/or needed for this individual. If not, the plan should be revised be individualized. Also discussed was concern over taking a temperature for measuring hypothermia axillary because it measures temperature approximately one degree less than oral methods and as much as two degrees lower rectal temperature. The method of assessing for core body temperature related to hypothermia should be discussed with the Medical Director. There was no documentation in the medical record indicating that the direct care professionals had been trained in the established HMPs.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement	Since the last review the State Nursing Workgroup had finalized (February 2011) several nursing policies/procedures/protocols: Competency Based Training Curriculum-Agency/Contract Nurses, Nursing Documentation Guidelines, Pre-treatment and post-	Noncompliance

#	Provision	Assessment of Status	Compliance
	nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	Sedation Monitoring, Management of Acute Illness and Injury, Seizure Management, and Medication Administration Guidelines. Review of these policies/procedures/protocols demonstrated significant improvement over the previous policies/procedures/protocols. The only concern identified was with the Acute Illness and Injury Procedure that stated, "When signs and symptoms of an acute illness or injury are present the nurse will complete a focused assessment as soon as possible but no later than one (1) hour after notification/observation of symptoms." Having the hour leeway result in delaying care that may require immediate or urgent attention. This statement should be reconsidered to ensure that nurses respond timely according to the situation to prevent delay in care. The Acute Illness and Injury Nursing Care Flow Chart developed through a statewide workgroup was impressive and should provide the nurses with a visual cue for decision-making. The State Nurse Educator Workgroup was in the process of finalizing the State Supported Living Center Nurse Education Handbook that will standardize competency-base training across all Facilities. The standardization of nursing education should enhance the quality of care and assist the Facilities in reaching compliance with this provision of the Settlement Agreement. Since the last review the Nursing Department's Policies, Procedures, and Protocols were better organized and up dated. A list of current Nursing Operating Policies, Procedures and Protocols is included in this report as a benchmark for future compliance reviews. Nursing Operating Policies, Procedures and Protocols included: • Nursing Services Policy • Lippincott Manual of Nursing Practice, Ninth Edition • Health Care Protocol for Developmental Disability Nurses • Care Plan Development • Communication with Hospitals and other Acute Care Facilities • Weight management Procedures • Weight Management Guidelines-Team Roles • Nurse Competency Based Training Curriculum • Self Administration of medications • Comprehensive Nursing Assessment Guidelines • Medication Error Reporting • Neurological Assessment • Post Anesthesia Care-Nursing Protocol • Competency Based Training Curriculum-and Agency Contract Nurses • Medication Administration Guidelines • Nursing Documentation Guidelines • Seizure Management Nursing Protocol	

#	Provision	Assessment of Status	Compliance
		• Vagal Nerve Stimulator Protocol - draft • Management of Acute Illness and Injury - draft • Pre-Treatment and Post-Sedation Monitoring by Nursing Protocol - draft • Nursing Peer Review Policy – draft The Restraint Policy and Procedures were discussed with the State Office Nursing Coordinator and CNE. The policy and procedures related to the requirements for nursing monitoring of the various types and situations for which "chemical restraints" were administered and the various forms nurses were required to document for monitoring activities seemed to result in confusion and disorganization in understanding the frequency of nursing monitoring that is required for the different chemical restraint usages and the method of documentation. The State Office Nursing Coordinator agreed and will consider revising the policies and procedures to include all forms of chemical restraint usage and clarify all nursing responsibilities for monitoring and documentation. A telephone conference was conducted with the State Office Nursing Coordinator, CNE, Monitoring Team, and Connie Horton, Nurse Practitioner Consultant, regarding the State's plan for enhanced competency-based training for physical assessment, care planning and critical thinking skills. A copy of the draft training curriculum and process for training, competency-based testing, and training materials were reviewed and discussed. The facility Nurse Educators were in the process of receiving the training by the nurse practitioners. The training consists of didactic instruction as well as "hands on" clinical practicum. The facility Nurse Educators will provide the training and competency testing for the facility RNs with oversight provided by the Nurse Practitioner Consultant. All RNs will be expected to take the physical assessment training including the nursing administrative staff. In addition to the training, the State planned to supply all the RNs with the Mosby/Elsevier Nursing Diagnosis Handbook, Eighth Edition, as an adjunct to the competency-based training. The package of materials included textbooks, lab manuals, and online resources. The Monitoring Team agreed that the RNs need enhanced training for physical assessment based on previous reviews. It is apparent that the RNs need enhanced training in the area of physical assessment. It will be a tremendous undertaking on the part of the State and facilities to provide training to RNs statewide. The Monitoring Team asked the State Office Nursing Coordinator to provide a list as RNs were trained. It will be important for the Monitoring Team to evaluate for improvement in terms of reviewing nursing assessments and care plans. Individuals residing in developmental centers have numerous co-morbid conditions and many are aging; therefore; it is imperative that the RNs be able to exercise critical thinking skills in taking their assessment findings and applying them to developing, implementing, and evaluating plans of care that are individualized, have realistic goals and that objectives meet individuals 'unique need for care.	

#	Provision	Assessment of Status	Compliance
		According the Facility's POI on 8/28/10, a policy regarding the Management of Oxygen Levels was sent out by the Medical Director. On 9/28/10, the CNE sent an e-mail to all nursing staff regarding notifying physicians/nurse practitioners of acute illness, including reiteration of the use of Situation, Background, Assessment, Recommendation and Summary (SBARS) when reporting to physicians/nurse practitioners. This also included assessing lung sounds and bowel sounds following incidences of emesis, and reporting abnormal findings to the physicians/nurse practitioners. Refer to Section L.1 regarding comments on the policy for Management of Oxygen Levels. Since the last review it was positive to find that the Nursing Department now had two well qualified, experienced, and motivated Nurse Educators. Significant improvements had been made over the last six months to revamp nursing education. The Nurse Educators were in the process of developing formalized, competency-based lesson plans for all nursing education. The lesson plans recently developed include objectives, content/guidelines, timeframe, presenter, teaching method, resources, and references. Review of the lesson plans developed thus far demonstrated improvement in content and incorporated relevant policies into the training. This was validated by review of the following policies: • Neurological Assessment and Documentation: Your Professional Responsibilities • Hospitalizations, Transfers, and Discharges • Charting and Documentation: Your Professional Responsibilities • Return for Hospital/Infirmary to Home • New Drugs Prescribed • New Med Pass Competency Checklist • "Medical/Dental/Events" Recent training provided included: • Skills Fair Summary – Competency-based, 2/23/11 o Neurologic Assessment o Gastrointestinal Assessment o Respiratory o Respiratory Assessment o New Neurological Assessment and Documentation Policy o Hospitalization, Transfers and discharges – New Policy o Responding to the "Trigger" form o Charting and Documentation o New Drug Prescribed – Documentation and Teaching o New Med Pass Competency Checklist o Post Anesthesia Care	

#	Provision	Assessment of Status	Compliance
		o Return from the Hospital • On 1/20/11 the Nurse Case Manager started individual training with each RN Case Manager to improve documentation of the nursing summary on the Comprehensive Nursing Assessment. Review of the Comprehensive Nursing Assessment training material was comprehensive and targeted to assist the Nurse Case Manager to analyze raw clinical data and formulate a summary that measures individuals' progress toward achieving established goals and objectives. As individual Nurse Case Managers had received individual training and mentoring, the assessments were beginning to show improvement. • The "Call a Nurse For…" training poster was initiated and edited by DSSLC Leadership Team. It was then sent to the unit directors for training of direct care staff. It was also implemented as a new curriculum for new employees' orientation on 2/16/11. The unit nurses reported to the Nurse Educators that the implementation had been successful and they feel they were being notified quickly of potential illness. All direct care staff were trained in January 2011. Training records were maintained by Competency Training and Development. The "Call a Nurse For…" training and flyer information contained the following information: o General Signs and Symptoms • Pain • Changes in temperature • Changes in pulse • Changes in respiration o Signs and Symptoms of Specific Bodily Systems • Skin • Respiratory • Digestive System • Nervous System • Urinary System o It is better to over-report than under report • At the time of the review the Nurse Educators were in the process of developing in-service training for nurses on the signs, symptoms, and management of Sepsis and an accompanying Memory Jogger for Sepsis. It was positive to find that Nurse Educators developed and implemented a database for tracking all required training to ensure that 100% of the nurses receive the training and that training was completed within the specified timeframe. For nurses delinquent in training, the database projected date for completion. The tracking database was implemented on 3/1/11. The list below validates the percentage of nurses trained to date and can be used as a benchmark for future compliance reviews:	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
Nursing Standardized Procedures –Protocols – Guidelines
<table>
<tr><th>Procedures/Protocol/Guidelines</th><th>% of Nurses Trained</th><th>Projected Completion Date</th></tr>
<tr><td>Documenting when a new drug is prescribed</td><td>56%</td><td>5/23/11</td></tr>
<tr><td>Return from Hospital to Infirmary</td><td>54%</td><td>5/23/11</td></tr>
<tr><td>Responding to “Trigger” form</td><td>55%</td><td>5/23/11</td></tr>
<tr><td>Pre-Treatment and Post-Sedation Monitoring Nursing Protocol</td><td>50%</td><td>5/23/11</td></tr>
<tr><td>Communication with Hospitals and Other Acute Care Facilities</td><td>53%</td><td>5/23/11</td></tr>
<tr><td>Self Administration of Medications</td><td>45%(of those required)</td><td>5/23/11</td></tr>
<tr><td>Neurology Assessment Policy</td><td>52%</td><td>5/23/11</td></tr>
<tr><td>Post Anesthesia Care – Nursing Protocol</td><td>51%</td><td>5/23/11</td></tr>
<tr><td>Doing an Abdominal Assessment</td><td>51%</td><td>5/23/11</td></tr>
<tr><td>Doing a Respiratory Assessment</td><td>52%</td><td>5/23/11</td></tr>
<tr><td>Doing a Neurological Assessment</td><td>52%</td><td>5/23/11</td></tr>
<tr><td>Medication Administration Guidelines</td><td>57%</td><td>5/23/11</td></tr>
<tr><td>Nursing Documentation Guidelines</td><td>55%</td><td>5/23/11</td></tr>
<tr><td>Nursing Standardized Abbreviation</td><td>Due to be implemented 5/10/11</td><td></td></tr>
<tr><td>Seizure Management Guidelines</td><td>Due to be implemented 5/10/11</td><td></td></tr>
<tr><td>Vagal Nerve Stimulator</td><td>Due to be implemented 5/10/11</td><td></td></tr>
<tr><td>Management of Acute Illness</td><td>Due to be implemented 5/10/11</td><td></td></tr>
</table>
At the next review the Monitoring Team will follow-up to evaluate nurses’ compliance with receiving required training.
</td><td></td></tr>
<tr><td>M5</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18</td><td>Since the last review, on 11/2/10 the State and Facility had developed the At Risk Individuals Policy and Procedure. On 1/1/11 the Facility implemented the new At Risk Individual Policy and Risk Guidelines. On 1/5/11 the Facility identified individuals who</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
	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.	were at high risk. All individuals diagnosed with Aspiration Pneumonia were to have risk assessments completed by 3/31/11. The remaining individuals' will have risk assessment ratings completed as their annual Personal Support Plans become due or as acute episodes warrant. Information derived from the risk assessment ratings directs the development of Health Management Plans. With the implementation of the new At Risk Individual Policy, the Health Status Teams no longer exist. The new policy indicated that nursing along with the physician/nurse practitioners were responsible for assessing risk factors for the following categories: • Aspiration • Respiratory Compromise • Cardiac Disease • Constipation/Bowel Obstruction • Diabetes • Gastrointestinal Problems • Seizures • Skin Integrity • Infections • Fractures • Fluid Imbalance • Hypothermia • Urinary Tract Infections • Circulatory Review of the Personal Support Planning Process, Policy/Number: CMGT-12.01 identified problems with the Policy section, II, D., 2., e., vi., "supports needed in the following areas:" The list includes medical, including identification of health risks, but does not identify nursing as a distinct discipline. The information contained in the Medical Section combines nursing services into the medical discussion. Although nursing works collaboratively with medical, nursing is a separate discipline and should be recognized as such. By not recognizing nursing as an equal clinical discipline, as were included for the other clinical disciplines, there is the potential to omit services and supports unique to the discipline of nursing which are not medically oriented and to limit the review and identification of risks by nurses. Through review of individuals' Personal Support Plans, nursing services and supports were frequently not included or were limited in assessment and planning content contained in the Medical Section of the PSP. This limited nursing assessment was obvious in review of the individuals' PSPs listed below. The Monitoring Team reviewed PSP and associated risk factors which were completed	

#	Provision	Assessment of Status	Compliance
		after 1/1/11. PSPs were reviewed for Individuals #339, #606, #645, #503, and #524. The Monitoring Team attended the Personal Support Team Meeting, 3/29/11 for Individual #524. The meeting was facilitated by the Occupational Therapist. Members in attendance included: Qualified Mental Retardation Professional, Behavioral Coordinator, Physician, Nurse Case manager, CNE, NOO, and Dentist. The individual and Legally Authorized Representative/Family were not present. The facilitator did an outstanding job by running an efficient and effective meeting. It was positive to find that all team members actively participated in the risk assessment. Each item on the Risk Assessment Tool was thoroughly addressed, consideration was given to the history and current status of the risk factors identified as well as precipitating factors that may have contributed to developing such risk factors. After the risk factors were identified and rated, a plan was discussed for each risk factor. The meeting was far more productive than the previous Health Status Team meeting attended. This approach with only Individual #524's team members present who knew her best and with more time to complete the risk assessment produced a more realistic, thoughtful, and accurate assessment with a tangible plan formulated. Listed below are the ratings for each risk factor identified: • High Risk Factors: Aspiration Pneumonia, Osteoporosis, Seizure, Polypharmacy, and Dental • Medium Risk Factors: Cardiac, Gastrointestinal Problems, Infection, Hypothermia, and Constipation • Low Risk Factors: Chocking, Weight, Diabetes, Skin Integrity, Fluid Imbalance, and Urinary Tract Infection The Monitoring Team will follow-up on Individual #524 at the next review to evaluate the Health Maintenance Plans derived from the identification of risk factors and the effectiveness of the plans. The Monitoring Team reviewed Individual # 339's PSP completed on 2/18/11. Relevant disciplines and the Legally Authorized Representative were present at the PSP meeting but Individual #339 and the Mental Retardation Authority Representative were not present. The Aspiration Pneumonia/Enteral Nutrition Evaluation was completed on 2/2/11l the individual was rated at high risk for Aspiration Pneumonia. The Integrated Risk Rating and the At Risk Action Plan were completed on 2/18/11. Individual #339 was rated at high risk for: Aspiration Pneumonia and Osteoporosis; rated at medium risk for: Choking, Gastrointestinal Problems, Seizures, Polypharmacy, and Challenging Behavior; rated low risk for: Weight, Cardiac, Circulatory, Constipation, Diabetes, Skin Integrity, Infections, Falls, Fractures, Fluid Imbalance, Urinary Tract Infection, Hypothermia and Dental. A rationale was documented for each of the risk factors	

#	Provision	Assessment of Status	Compliance
		reviewed. A Risk Action Plan was developed for all high and medium risk factors to decrease the possibly of incidents or complications of the identified health risks. Individual #339 had Nursing Health Maintenance Plans for: Aspiration Pneumonia, Osteoporosis, Seizures, Skin Integrity, Constipation, Gastritis, Urinary Tract Infection, and Under Weight. There was no Health Maintenance Plan for Polypharmacy. The Monitoring Team identified a major concern during in review of Individual #339's PSP documentation. The Physical and Nutritional Management Section mentioned continuing concerns regarding the color of hands, legs and feet. Individual #339 was rated low for cardiac and circulation issues. The rationale listed in the Integrated Risk Assessment for the circulatory risk factor stated, "Recently reported to have cool hands/feet with purple color may [be] from poor circulation. Due to hip/knee contractures PT (passive ROM contraindicated) recommended tilt w/c at this time." The rationale listed for the fluid imbalance risk factor was poor circulation of lower extremities. While a tilt in place wheelchair would no doubt be helpful with circulation of the lower extremities, it probably would not resolve cool hands, if circulation was the problem. There was no discussion in the PSP documentation reviewed that indicated Individual #339 had a cardiac/circulatory medical evaluation to rule out the underlying cause of the circulatory problem; nor was there a recommendation to do so. The Monitoring Team reviewed Individual # 606's PSP completed on 2/8/11. Relevant disciplines were present at the meeting as well as Individual #606 and the Legally Authorized Representative. The Mental Retardation Authority Representative was not present at the meeting. The Integrated Risk Assessment was not included in the documents received for review. The PSP's "Medical including identification for health risks" was poorly written and it was difficult to discern precisely what Individual #606's risk factors were. The only specific risk factors listed included medium risk for Choking, Aspiration, Respiratory compromised. It was not possible from the narrative to determine what the ratings of risk factors were related to the health problems mentioned e.g., Constipation/Bowel Obstruction, Diabetes, Osteoporosis, Polypharmacy, GERD, and Challenging Behaviors. Individual #606 had Nursing Health Maintenance Plans for: Constipation, Skin Integrity, Falls, Tinea Pedis, Pneumonia, Diabetes, and Hypertension. The Medical section of the narrative was grossly inadequate to understand Individual #606's medical/health risk problems and need for care. The Monitoring Team reviewed Individual #645's PSP completed on 1/27/11. Relevant disciplines were present at the meeting including Individual #645 and the Legally Authorized Representative. The Mental Retardation Authority Representative and Personal Support Assistant were not present. The Integrated Risk Rating assessment was completed during the PSP team meeting. Risk factors were identified as: medium risk for: Choking, Gastrointestinal Problems, Osteoporosis, and Challenging Behaviors.	

#	Provision	Assessment of Status	Compliance
		All other risk factors were rated as low. Individual #645 had Nursing Health Maintenance Plans for: Skin Integrity, Seizure, Gastritis, and PICA. There were no Health Maintenance Plans for Choking and Osteoporosis (Osteopenia). The Monitoring Team reviewed Individual #503's PSP completed on 3/4/11. Relevant disciplines were present at the meeting including Individual #503, Legally Authorized Representative, and Mental Retardation Authority Representative. Individual #503's Personal Support Assistant was not present. The Integrated Risk Rating assessment was not included in the documents requested for review. According to the PSP Individual #503 did not have any medical risk factor. Individual #503's had a Service Objective for Skin Integrity that was to be monitored twice a year or as needed.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Since the last review it was readily apparent through review of the POI Evidence Book, documents, interviews, and observations that the Nursing Department had continued to make improvements in their medication administration system. Most noticeable was the efforts put forth by the Facility Administration and the Nursing Department to provide individuals' privacy during medication administration. Nursing administration worked with Space and Physical Environment to identify a private space in each apartment and the Infirmary for medication administration. This was validated through review of each Unit and the Infirmary building floor plans where the locations for administering medications were color coded and a note written on the floor plan describing the location. In apartments where an empty room was available those rooms were used. Due to the limited space available, areas free from traffic were located. Privacy screens were used in open areas for medication administration. Only one apartment had a medication room where medications could be administered. The direct care professionals assisted the nurses during medication administration by bringing individuals to the nurse for their medication. This was a positive finding because it assured that the individuals received their medications on time and helped with traffic control. Since the last review the Pharmacy was able to modify the WORx computer system to add on to the Medication Administration Record the number of pills required to equal a total dose. This was a significant improvement and should help reduced medication errors. The Pharmacy was also in the process of adding the MAR medications that need to be crushed when individuals were prescribed an alteration in their diet textures. This was a positive finding that will aid in the prevention of individuals choking on medication because the texture was not compatible with their prescribed texture. The Medication Administration Observation system continued to be well organized and effective. The Quality Assurance Nurses continued to be responsible for completing quarterly Medication Administration Observations on each nurse administering	Noncompliance

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		medication. Review of the Medication Pass Enteral Feeding Nursing Observation Schedule for 2011 indicated that each nurse was scheduled. Review of the completed Medication Observation Monitoring Tools indicated that corrective action was taken "on the spot" when deficiencies were identified. Monthly, the Quality Assurance Nurses calculated the percentage of compliance for each item on the Medication Administration Observation Monitoring Tool and then, overall rate of compliance for each living area and Infirmary, as well as calculating the overall Facility rate of compliance with the tool. The completed Medication Administration Observation Tools with the summarized reports indicating the rate of compliance were submitted to the Unit Nurse Managers as well as Nursing Administration. These data were also included it the Quality Assurance and Quality Improvement Committee Reports as Medication and Administration and Documentation. In January 2011 Quality Assurance Nurses began using the Medication Administration Observation Monitoring Tool that was revised in accordance with the State's Section M, Nursing Care: Medication Administration and Documentation Monitoring Tools and Medication Administration Policy. Review of the overall Facility reports for January and February 2011 using the revised tools revealed the following findings, which will be used as a benchmark for future compliance reviews: Medication Administration Observations for January 2011 • Overall rate of compliance with the tools was 95%. Items falling below 100% compliance included: o Authorized physician prescribed order, Medication Administration Record (MAR) are in agreement for those individuals for the upcoming medication pass. Met 95% compliance. o Medications are pulled for the current med pass only. Met 97% compliance. o Pill crusher is cleaned per medication administration policy. Met 31% compliance. o If, ordered, crushed medication and/or specialized instructions are noted on the MAR. Met 92% compliance. o Each medication is being administered within the appropriate start and stop order dates before the nurse administers the medication. Met 98% compliance. o Medications are administered according to prescription in terms of right person, right drug, right dosage, right time, and right route. Met 94% compliance. o Insulin was administered properly per policy. Met 75% compliance. Medication Administration Observations for February 2011	

#	Provision	Assessment of Status	Compliance
		• Overall rate of compliance with the tools was 98%. Items falling below 100% compliance included: o Nurse washes hands at beginning of medication pass or uses alcohol gel before re-washing hands. Met 97% compliance. o The nurse cleans medication cart and work area prior/during administration of medication. Met 98% compliance. o Medication storage area is secure when not in use. Met 98% compliance. o Medications are pulled for the current med pass only. Met 99% compliance. o Pill crusher is cleaned per medication administration policy. Met 56% compliance. o The MAR is complete for signatures. Met 99% compliance. o The MAR notes all known allergies. Met 98% compliance. o Master signature list initials match the initials on the MAR. Met 97% compliance. o Medications are documented as they are administered (before the next person). Met 94% compliance. o Medications are secured during administration. Met 99% compliance. o Medications are administered within one hour of time indicated on MAR. Met 89% compliance. When this Medication Administration Observation data were compared to the data from the last review, it showed steady improvement in overall compliance ratings, as well as for individual items on the tools. The area found most deficient was failure to keep pill crushers clean. There was documented evidence on the tools for each instance that the pill crushers were found dirty that the Quality Assurance Nurse provided "on the spot" re-training and notified to the respective Nurse Manager. The Monitoring Team completed Medication Administration Observations, including medication administered enterally, in the Infirmary and in Garden Ridge West. The nurses observed administering medications followed correct procedures for administering medications, with one exception. One of the nurses started initialing the medications as they were pulled and checked before administering. The NOO accompanying the Monitoring Team promptly corrected the nurse and she stopped and continued to correctly document the medications after they were administered. The nurse administering medications in the Infirmary gave the medications in the dayroom protected by a privacy screen. The nurse in Garden Ridge West gave medication in a back hallway free from traffic using a privacy screen. The direct care professionals assisted the nurse by bringing individuals to the nurse for medication. The environment	

#	Provision	Assessment of Status	Compliance
		was quiet and free from distractions. This was not the case at the last compliance visit. The nurses implemented individuals' Self Administration Plans as scheduled. Individual #732 had a PNMP that included instructions for medication administrations, e.g., medications must be crushed and mixed with pudding. The nurse was knowledgeable of Individual #732's PNMP and followed instructions for administering medications. The March 2011 MARs for the individuals observed contained no blank blocks indicating medications were omitted. If a medication was not administered a circle was drawn in the block and an explanation written on the back of the MAR. Individual #725 received Tylenol 650 milligrams at 1425 and 2000 but the response to the Tylenol was not documented on the back of the MAR. The Narcotic Logs for building 526 A and B were not consistently signed by two nurses at each shift. The nurse explained that often she worked double shifts and usually she had a nurse working on the other side of the building sign with her. This was discussed with the NOO, Garden Ridge Nurse Manager, and staff nurse; all agreed that two nurses must sign the Narcotic Log each shift. Overall the medication administration observations this review demonstrated significant improvement from previous reviews. It was observed that some of the medications were administered from stock medications, e.g., Calcium/VitD 250/125 tablets and Cholecalciferol 800 Units, and Polyethylene Glycol Powder. Monitoring Team asked to see the storage for stock medication. The locked medication cabinet in the medication room contained a variety of over the counter stock medications. A copy of the stock medication list was requested and received that contained many stock medications for the Units and Infirmary. The Facility's Pharmacy Consultation and Oversight Committee, Committees and Councils – 09 November 1, 2009, General Responsibility and Authority, page 2, number 9, stated, "r*eview the Loan and Borrow Log for frequency and quantities loaned or borrowed*." The Monitoring Team reviewed monthly Medication Error Committee Meeting Minutes, 12/31/10, 1/26/11, and 2/17/11. The committee was chaired by the CNE. Committee members included the NOO, Nurse Managers, Nurse Case Manager Supervisor, Quality Assurance Nurses, Nurse Educator, Pharmacist, Staff Nurse, and when needed Data Analyst. The organization, structure, and content of the meeting minutes showed improvement from previous reviews. Medication Errors Trending Reports were reviewed and discussed at the meetings, which included discussion of probable causes along with efforts to reduce the incidents of errors as well as review and discussion of findings from the Medication Administration Observation Reports with focus on items falling below 80% compliance. Corrective actions were identified for items found deficient. The need to revise the Medication Error Database was discussed and it was decided to include probable causes of medication errors and to report medication errors	

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		monthly as opposed to weekly. In January the Data Analyst was requested to make the changes. While Medication Error data were represented in tabular form with number of errors represented weekly/month for each Unit and the Infirmary the minutes did not quantitatively report the number of medication errors and disposition in the body of the minutes. The Medication Error Committee needs to summarize medication errors in the minutes of the meetings. The Monitoring Team reviewed the quarterly Pharmacy and Therapeutic Committee Minutes, 12/24/10 and 12/28/10. The minutes contained little information regarding medication errors committed by the nursing staff. There was the discussion of adding the number of tablets to equal the total dose on the MARs as well as adding direction on the MARs regarding the need to crush medications for individuals who where prescribed an alteration in diet texture. The 12/24/10 minutes stated that the CNE discussed medication errors at the monthly Medication Error Committee Meeting for which the majority of the errors were due to omission and incorrect dosage administered; however, the minutes failed to include the number of errors. In the 12/28/10 minutes there was a discussion by the CNE that explained her plans to revise the medication error tables and graphs to assist with focusing on the types of medication errors and the areas and shift errors that occurred so that an in-depth review could assist with procedural changes, MAR changes, and training for the appropriated staff and areas. The number of medication errors committed by the nursing staff was not reported. The Monitoring Team attended the Pharmacy and Therapeutic Committee Meeting on 3/29/11. The meeting was chaired by the newly appointed Pharmacist. The CNE explained to the Monitoring Team that the quarterly Medication Error Report was in error because it contained inaccurate data. Potential medication errors had been added to the data. The CNE stated she would reconcile the data and have the Data Analyst make the corrections. The correction was not made by the time the review ended. The CNE did not explain what potential medication errors had been added; if this referred to errors that did not reach the individual, these should be included and reported in a comprehensive medication variance review system. Refer to Section N for more details regarding the Pharmacy and Therapeutic Committee. Review of the recently revised Medication Error Database indicated numerous improvements. By using the Root Cause Analysis approach to investigate medication errors, it will provide a more thorough understanding as to what happened to cause the error and can then lead to appropriate and meaningful corrective action plans. The database tracks medication errors in the following ways: • By Unit/Infirmary, by type of error • By shift	

#	Provision	Assessment of Status	Compliance
		• By nurse committing the error • By individual for whom the error was committed • By Category Index • By probable cause The Monitoring Team reviewed the last 10 Medication Error Reports submitted in the document request. It was positive to find since the last review significant improvements were made in their ability to thoroughly complete the reports, identify errors within 24 hours, report the errors to the physicians, and for the Nurse Managers to take corrective action with the nurses committing the errors, as demonstrated below: • 10 or the 10 (100%) were filled out completely and accurately. • 10 of the 10 (100%) were discovered within 24 hours or less. • 10 of the 10 (100%) the of the errors where reported to the physicians within 24 hours • 10 of the 10 (100%) had corrective action taken by the Nurse Managers. The date and time the Nurse Managers took corrective action with the nurses were not documented. However, the Medication Error Report Form does not contain a space for date and time. As a matter of prudent practice to ensure that nurses' receive prompt corrective action to prevent future medication errors, the Nurse Managers need to document the date and time that the corrective action took place. The Nursing Department needs to advise the Nurse Managers to include the time and date they took corrective action with nurses committing medication errors to ensure that corrective action was taken promptly. • 9 of the 10 (90%) of the Category Indexes were marked correctly. One was marked Category C, when it should have been marked as a Category D, e.g., an error occurred that reach the individual and required monitoring to confirm that it resulted in no harm and/or required intervention to preclude harm. The individual received Zypreza in the place of Abilify. The physician ordered to hold the Abilify today and place on 24-Hour Nurse Watch.	

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

1. The Nursing Department needs to continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement as well as meeting the established minimum nursing ratios.
2. The Nursing and Quality Assurance Departments' need to ensure that the nursing staff completing the Nursing Monitoring Tools critically evaluate clinical issues with the focus on the quality of nursing services and supports, e.g., the appropriateness and efficacy of the care rendered to meet individuals' unique health care needs, as opposed to merely checking off the items contained on the tools.
3. The Nursing Department needs to continue to improve documentation.
4. While the use of electronic communication is a quick and efficient method of communication, the Facility needs to evaluate how electronic communication can be incorporated into individuals' official medical record.

5. When the State Office rolls out the Physical Assessment Training the Nursing Department needs to ensure that all Nurse Managers and Nurse Case Managers receive the competency-based training on Physical Assessment.
6. The Nursing Department needs to ensure:
    a. HMPs and ACPs are individualized beyond the baseline data and goals.
    b. The current operating HMPs and ACPs are in the individuals' official medical record.
    c. When HMPs and ACPs are established that documentation is written on the HMPs and ACPs, and in the Integrated Progress Notes validating that direct care professionals were trained.
    d. When the Quarterly Comprehensive Nursing Assessment are completed the Nurse Care Managers must review and revise the HMPs and ACPs, and then document on the HMPs and ACPs that it was done.
7. The Facility needs to conduct a problem focus analysis on the high incidence of conjunctivitis, which is a contagious disease that is easily spread and requires meticulous hand washing and standard precautions to prevent its spread. The incident of MRSA infections also needs examination.
8. The Nursing Department should provide the Infection Control Nurse with the assistance of an Infection Control expert or formalized training in Infection Prevention and Control for Long-Term Care Facilities.
9. The Facility's Incident Management Review Team needs to more thoroughly explore precipitating factors that contribute to Aspiration Pneumonia and make substantive recommendations for prevention.
10. The Infection Control Nurse needs to become a permanent member to the Incident Management Review Team.
11. The Facility needs to ensure that hand washing is monitored routinely, data analyzed and trends reported, along with corrective action, both systemic and individual, put in place when there are errors in following proper hand washing at all times to prevent the spread of infection as well as for compliance with the Settlement Agreement and Health Care Guidelines.
12. The Facility needs to ensure that Standard Precautions and Environmental Surveillance are monitored routinely, data analyzed and trends reported, along with corrective action, both systemic and individual, put in place when there are errors in following proper hand washing at all times to prevent the spread of infection as well as for compliance with the Settlement Agreement and Health Care Guidelines.
13. The Facility needs to aggressively insist that employees complete annual Tuberculosis Screenings.
14. The Infection Control Nurse should collaborate with the Pharmacy and physicians in reviewing the use of antibiotics and monitoring for appropriateness.
15. The Infection Control Nurse should monitor antibiotic susceptibility results from cultures to detect clinical significant antibiotic-resistant bacteria, such as MRSA, VRE, and Pseudomonas aeroginosa. Changes in antibiotic-susceptibly trends should be communicated to appropriate clinical staff and Infection Control Committee.
16. The Medication Error Committee and Pharmacy and Therapeutic Committee need to summarize medication errors in the minutes of the meetings.
17. The Nursing Department needs to advise the Nurse Managers to include the time and date they took corrective action with nurses committing medication errors to ensure that corrective action was taken promptly.

The following are offered as additional suggestions to the facility:
1. The Facility needs to ensure that the Abbreviation List includes all acronyms used as well as standard abbreviations.
2. The Facility should to strongly encourage employees to receive their annual influenza vaccine.

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 State Supportive Living Center (DSSLC) Plan of Improvement (POI) 3/15/11 2. Drug intervention reports for individuals: #605, #119, #178, #496, #452, #395, #765, #201, #310, #279, 567 (x2), #341, and #620 3. Twelve months of laboratory data, six months of Moses, six months of medication records, and DISCUS reports for individuals #605, #232, #540, #127, #423, #669, and #494 4. Quarterly Drug Regimen Review, along with laboratory data, DISCUS and Moses assessments for individuals residing on unit 502C, for the Month of January, 2011 (Individuals: #188, #715, #362, #323, #545, and #654 5. Active clinical record for Individuals: #605, #119, #178, #496, #452, #395, #765, #201, #310, #279, 567, #341, and #620 6. Drug Intervention Guidelines, dated November 11, 2010 7. Pharmacy policy-26, Pharmacy Quarterly Drug Regimen Reviews, dated August 5, 2010 8. Positive Behavior Support Limitation of Restraint as a Crisis Intervention policy and procedure, dated 11/5/2009 9. Restraint Documentation Guidelines for State Supported Living Centers dated November 2008 10. Restraint Checklist, Face-to-Face Assessment forms 11. Processes for Adverse Drug Reaction (ADR) Reporting, dated 7/26/10 12. ADR reports for Individuals #102, #276, and #291 13. Medwatch form FDA 3500A 14. Review Processes for Drug Utilization Evaluation, dated November 12, 2010 15. Warfarin DUE Initial Submission, July 28, 2010 16. Phenytoin Introduction, Part 2, undated 17. Pharmacy and Therapeutics Committee (P&TC) minutes dated November 15, 2010 18. "Med Order Variance" report, dated 12/26/10 19. New Medication Order Review document dated October 18, 2010 **People Interviewed:** 1. Jana Boone, Director of Pharmacy **Meetings Attended/Observations:** None
	Facility Self-Assessment: N1. The Facility reports substantial compliance with Provision N.1, of the Settlement Agreement. To demonstrate compliance, the Facility reported to the Monitoring Team that they enhanced the pharmacists' ability to review new medication orders by ensuring that the electronic prescription ordering system, WORx, was reprogrammed to enable verification of maximum dosages for psychoactive medications along with prompts for verifying laboratory orders for antiepileptic drugs (AEDs). The Facility also reported that

	they had enhanced pharmacists' reviews of new drug orders by ensuring that clinicians complete each order appropriately and document relevant issues on the Drug Intervention Documentation form, which is maintained electronically. Other enhancements included the pharmacy issuing a "Do Not Crush" medication list to nurse educators and nursing staff at the Facility. The WORx system was also programmed to notify pharmacists when an individual is prescribed a special diet (pureed or ground texture or requiring enteric tube feeding), thereby allowing the pharmacist the ability to ensure that medications prescribed are suitable for the prescribed diet. The Monitoring Team clearly recognized the benefits of these enhancements. The Monitoring Team, however, identified several issues relevant to Provision N.1, of the settlement agreement. Of primary concern is that both the pharmacists recommendations to clinicians, and the clinicians response to a drug intervention report must offer relevant clinical recommendations, and responses must be clinically justifiable. N2. The Facility reports that because they still do not have a full time clinical pharmacist completing the QDRRs, they remain noncompliant with Provision N.2, of the Settlement Agreement. The Facility reports that it continues to improve on completeness of the QDRRs. N3. The Facility commented that it continues to work towards substantial compliance with Provision N.3, of the Settlement Agreement; however, at the time of the review, the Facility determined that they were not in compliance with Provision N.3. In working towards compliance, the Facility reported to the Monitoring Team that it has enhanced its process in reviewing polypharmacy and the specific use of emergency chemical restraint by ensuring that there is a face to face debriefing that combines input from pharmacy and psychiatry whenever a stat medication is used. The Facility reports that they have experienced a decrease in the use of stat medications, anticholinergics, and general polypharmacy, since initiating this process. The Monitoring Team noted a substantial decrease in the use of these medications and compliments the Facility on this process. N.4 The Facility reported that they remain out of compliance with Provision N.4, of the Settlement Agreement. They indicated to the Monitoring Team that they are progressing towards compliance by ensuring that physicians appropriately document their clinical justification when not agreeing with the pharmacist's recommendation on the QDRRs. The Monitoring Team identified examples where the physician did not offer appropriate clinical justification on the QDRR's. N5 The Facility reported to the Monitoring Team that psychiatry is working with nursing to improve MOSES and DISCUS training and complete the screenings, and that during the QDRR, pharmacists ensure that the MOSES and DISCUSS are up to date. The Monitoring Team identified examples ofMOSES and DISCUS assessments that were not complete. Also, the process of training nurses is not complete. Importantly, the Monitoring Team strongly recommends that all professional staff who complete on these two assessment scales are appropriately trained. The Monitoring Team disagrees with the Facility's assessment of being in substantial compliance with Provision N.5.

	N6. The Facility reported to the Monitoring Team that they remain non-compliant with Provision N.6, of the Settlement Agreement and the Monitoring concurs with this finding. In working towards compliance, the Facility reported that they had an Adverse Drug Reaction reporting process in place. During its review, the Monitoring Team identified significant issues with the process and noted that staff are underreporting adverse drug reactions. N7. The Facility continued to report that they were noncompliant with Provision N.7 of the Settlement Agreement. They informed the Monitoring Team that they are making progress towards compliance by enhancing the drug utilization evaluation process (DUE) by enabling the Facility's P&T committee to make medication recommendations for a DUE, and that at least one DUE is completed every quarter. The Monitoring Team determined that the Facility's DUE process does not reach the level of standard of care practice that is necessary to enhance clinical outcomes. N8. The Facility notified the Monitoring Team that it is not compliant with Provision N.8, of the Settlement Agreement. The Facility reported that it continues to make progress towards substantial compliance. The Facility reports that it has developed a system to help prevent dosage errors by having pharmacy listing the actual number of tablets needed to make a full dose, on the Medication Administration Record. The Monitoring Team identified this process when reviewing active clinical records at the living area. The Facility also commented that it is tracking drug interventions by pharmacists; however, when asked by the Monitoring Team for the data analysis on drug interventions, the Facility had not developed a mechanism to perform actual trends analysis. The Pharmacy department tracks its near misses, dispensing errors and medication errors and reports a summary to the P&T, but there is no formal policy that outlines this process. Importantly, the Monitoring Team noted that nursing and pharmacy components of their medication variance process are independent of each other, and there is no involvement by physicians.
	Summary of Monitor's Assessment: Since the last Settlement Agreement review, the previous Pharmacy Director resigned and Jana Boone assumed the role of Pharmacy Director since February 2011. Subsequently, only limited enhancements were made towards substantial compliance with Provision N of the Settlement Agreement. The current Pharmacy Director is reviewing the department's policies and procedures and reviewing previous advances made by the previous Pharmacy Director. Following review of Provision N.1, the Monitoring team disagrees with the Facility's assessment and has determined that the Facility is not in compliance with the Provision. The Facility must enhance its policies to reflect the actual process for monitoring new medication orders, roles and responsibility of staff, documentation practice, and remedial action. The Facility must ensure that the pharmacist documents appropriate rationale and follow-up issues related to each intervention. Following its review of Provision N.2, because of lack of comprehensiveness and completeness of the quarterly drug reviews, the Monitoring Team has determined that the Facility remains non-compliant with the Provision.

	Because the Facility did not specifically monitor for metabolic syndrome, per standard of care protocol; did not specifically monitor the use of benzodiazepines and anticholinergic medications, or maintain a specific database for trends analysis of their use; and did not demonstrate a trends analysis for the use of STAT medications, the Monitoring Team concurs with the Facility's assessment and has determined that the Facility is not in compliance with provision N.3 of the Settlement Agreement. Secondary to the lack of comprehensive recommendations by pharmacists, and the physicians continuing to use the terms "will continue to monitor" and "the benefits outweigh risks", without providing appropriate clinical rationale, the Monitoring Team agrees with the Facility and has determined non-compliance with Provision N.4 of the Settlement Agreement. As a result on failure to complete prescriber reviews, lack of appropriate training on the use of DISCUS and MOSES, lack of inter-rater reliability assessments for the DISCUS and MOSES, lack of an effective mechanism to closely monitor individuals for side effects by all staff who work closely with individuals, no significant indication that individuals are monitored for side effects to medications outside of their scheduled DISCUS and MOSES, and not providing MOSES side effect scale to persons not on psychotropic medications, the Monitoring Team concurs with the Facility's assessments and has determined that the Facility is not in compliance with Provision N.5. The Monitoring Team concurs with the Facility's assessment and determines non-compliance with Provision N.6, of the Settlement Agreement. The Facility must immediately address its process on identifying, assessing and following up on adverse drug reactions. The Monitoring Team has determined that the drug utilization evaluation process, as presented, is a good start; however, continued enhancement in the process would be necessary before the Monitoring Team can find compliance with Provision N.7. Based on discussion with the Pharmacy Director and lack of supporting documentation requested by the Monitoring Team to demonstrate the existence of an integrated and unified process, Monitoring Team noted that the various responsibilities for the medication variance process were fragmented, physician staff were not involved, there was a lack of comprehensive data collection for the medication variance program, no formal policies for a comprehensive medication variance program existed, and there was a lack of formal policy and process on providing remedial action for medication variances, the Monitoring Team has determined that the Facility remains non-compliant with Provision N.8, of the Settlement Agreement.

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N1	Commencing within six months of the Effective Date hereof and with	To assess compliance with Provision N.1, the Monitoring Team discussed the Facility's efforts with the Director of Pharmacy, Dana Boone, requested policies and procedures	Noncompliance

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	full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	and reviewed intervention reports. According to the Director of Pharmacy, the Facility did not have a policy specific to Pharmacists interventions for new medications. The Facility did, however, have a guideline entitled "Drug Intervention Guidelines", dated November 16, 2010. The guideline does not appear specific to the Facility, and is not comprehensive, lacks specifics and does not delineate the entire process that the Facility completes when performing drug interventions. For example, the guideline states, "Front-end pharmacists will watch for additional information regarding pending interventions; if necessary, following up with clinic clerk, clinic nurse, or provider for requested information within 2 days." This statement does not provide guidance on how to "watch for additional information", how to ensure that the information is tracked, or in the event that the "front end pharmacist" is absent from work, how the information is shared with the covering pharmacist. The guideline also does not comment on appropriateness of documentation by the pharmacists, such as how to appropriately document (e.g., do not hand write on the form, or if doing so ensure to date, time and sign all entries), as well as appropriateness of the pharmacist's response when making a recommendation. There was no policy in place on how the Facility manages incomplete documentation practices and inadequate follow-up on interventions. There was no formal process for in-service training on monitoring new medication orders or expectations on the part of the nurse, physician and pharmacist. There was no process in place to provide remedial action for physicians, nurses or pharmacists for failure to appropriately document interventions, or provide appropriate recommendations when responding to recommendations. The Monitoring Team reviewed "Single Patient Intervention Report" forms on the following Individuals: #605, #119, #178, #496, #452, #395, #765, #201, #310, #279, 567 (x2), #341, and #620. • Individual #605: Sudafed was contraindicated due to interaction. Physician discontinued the medication. No alternative treatment or resolution of the condition was documented. • Individual #119 had known allergy to Omega-3 fish oil, which was ordered. Physician discontinued the medication. No alternative treatment was documented • Individual #178 had known allergy to iodine and was prescribed medication with iodine. Pharmacist sent physician an email notifying the physician of the contraindication and stated "do you wish to go ahead and give the " medication. The physician responded "yes" without providing any rationale or documenting an alternative considered but not chosen.	

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		• Individual #496. Individual has reported allergy to the medication. Pharmacist documented physician response for continuing the medication by stating "Think he has had before with no problem". Subsequent handwritten documentation on the form, which was not signed, timed or dated, stated, "has had (medication" numerous times in the past. Limited antibiotic choices due to many allergies. Dr. will monitor individual for reaction". No documentation on how monitoring will take place. The Monitoring Team did not see a subsequent order or note that supports enhanced monitoring of the individual. • Individual #452: Guaifenesin was on the individuals PRN medication list. Pharmacist noted that the individual has allergy to this medication. Physician discontinued the medication from the PRN list. • Individual #395 was provided duplicate prescription. Pharmacist documentation stated "Patient still has active order for Miconazole which needs to be dc'd". No follow-up documentation/comment was noted. • Individual #765: Pharmacist notified staff that prescribed medication (Carvedilol/clonidine) will result in serious adverse reaction if abruptly discontinued. Staff responded by stating "this should not be an issue since she is not discontinuing the clonidine." The pharmacist continued by stating "I stated that this is the warning for a potential discontinuation in the future." The Monitoring Team could not find further notification of the physician acknowledgment of this warning, or the PST's review of this important issue. All individuals who are prescribed this class of medication should have a specific health care plan that will ensure that this potentially life threatening situation will not occur, and that staff are made aware of signs to monitor for potential adverse effects. Given that the pharmacist made a second notice, it would have been appropriate for the physician to follow up to ensure a health plan was in place and to inform the pharmacist. • Individual #201: Individual was prescribed an antibiotic that interacted with another prescribed medication. Following notification by the pharmacist, the medication was changed to an alternate antibiotic. Follow-up and documentation was appropriate. • Individual # 310: Pharmacist notified the physician of drug-drug interaction between two medications prescribed. Pharmacist documented "She was aware of the interaction but felt that benefit outweighed risk." No clinical rationale provided. • Individual # 279: Pharmacists notified physician about severe drug-drug interaction. A hand written comment was documented. The written comment did not provide clear rationale or provide insight into the physician action. Also, the comment was not signed, timed or dated. • Individual #567: Pharmacist documented "Dr. wrote for prevpac-the Biaxin has	

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		sever intrxn with Tegretol s/potential to cause toxicity. Dr. will hold prevpac order, dc tomorrow morning and choose another regimen for H-pylori". The interaction was dated February 3, 2011 but follow-up orders were not received by the pharmacist until February 7, 2011. • Individual #341: Pharmacist documented "DR. GALBRAITH DC'D DUE TO INTERACTION WITH CLOPIDOGREL". No rationale or alternate treatment was documented. • Individual #620: On the drug intervention form, the pharmacist recommended medication change and noted that the physician will "write order" to change the medication. The pharmacist hand wrote a comment noting medication changes but it was not timed or dated. • Individual #567: Pharmacist notified physician on February 3, 2011, that she wrote a duplicate order and documented that the doctor "will change order in the morning.". Comment written by hand stated "new order received 2/7/11." This was days following notification. The Monitoring team disagrees with the Facility's assessment and has determined that the Facility is not in compliance with the Provision. The Facility must enhance its policies to reflect the actual process for monitoring new medication orders, roles and responsibility of staff, documentation practice, and remedial action. The Facility must ensure that the pharmacist documents appropriate rationale and follow-up issues related to each intervention.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	To assess compliance for Provision N.1, the Monitoring Team discussed current practice with the Director of Pharmacy, reviewed the Facility's policy on quarterly reviews – Pharmacy Quarterly Drug Regimen Reviews and reviewed the quarterly reviews on the following individuals. At present, the Facility did not have a certified clinical pharmacist; however, a registered pharmacist was conducting the Facility's QDRRs, until the posted position for a clinical pharmacist is filled. Following review of the Quarterly Drug Regimen Reviews, the Monitoring Team noted the following: • Individual #554. Pharmacist did not comment on previous sodium level of 130 (hyponatremia), elevated MCV of 106.7, RBC of 3.26 and WBC of 4.1. The individual was diagnosed with iron deficiency and was provided iron supplementation. Records reviewed did not provide an etiology for the iron deficiency anemia.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The etiology of iron deficiency anemia must always be explored. There was no comment noting that the Individual was on medications that can cause anemia, such as valproic acid, nor on a medication that can cause hyponatremia, carbamazepine. The pharmacist provided a recommendation to the physician stating that the last iron level was normal and suggested to decrease the dose of iron because it can be constipating. No recommendation was made to explore etiology of anemia or, given that the MCV was so elevated, that drug-induced anemia should be considered. Review of records indicated that a work-up for iron deficiency was initiated following the QDRR, and the results were within expected range (normal, with the exception of a slightly elevated TIBC). Most important, the reticulocyte count was also normal, as was B12 and Folate, which suggests something other then iron deficiency anemia. • Individual #323 Pharmacist noted that no recommendations were required and that "medication and related labs appear appropriate with regards to dose, indication, time of administration, monitoring and length of therapy." Other notes commented "Patient has slight anemia and leucopenia: As of 1/3/11, WBC were low at 3.4 and RBC was low at 3.78." No rationale, clinical explanation, nor need for evaluation was provided. • Individual #362 The individual was noted to have more frequent seizures following addition of a third anticonvulsant. There was no recommendation to increase monitoring for potential side effects to medications. Enhanced monitoring of side effects is essential following any medication change (increase, decrease dose or discontinuation). Importantly, the individual takes fiber supplements for significant constipation. Fiber supplementation may actually exacerbate constipation and potentially cause obstruction and perforation in some people, especially if they are not receiving adequate hydration. Also, fiber supplements may bind certain medications and affect their absorption and bioavailability. Such issues were not commented on. • Individual #715 o The individual was on Topiramate and Phenytoin for seizure disorder. The Topiramate dose was increased on 12/8/10 secondary to increased frequency of seizures on 11/10. Enhanced monitoring for side effects was not recommended nor ordered. The Pharmacist commented that the Phenytoin level was within normal levels at 12.1 on 12/1/10; however, there was no comment on the history of significant fluctuations in Phenytoin levels during the previous year. Blood levels varied between 7.4 (subtherapeutic) to 33.1 (potentially toxic). On June	

#	Provision	Assessment of Status	Compliance
		4, 2010, the level was noted to be subtherapeutic, at 7.7. A follow-up level was not obtained until 12/1/10, which demonstrated a level of 11.0 (low normal). This volatile pattern of drug levels should be explored as to the cause. Sometimes an individual may miss a dose of medication that is not reported, is co-administered medications that may interfere with the anticonvulsant, or administered along with foods that may prevent absorption. Important to this case, the person experienced increased frequency of seizure activity and was noted to have fluctuating levels of anticonvulsants; this issue should have been discussed at a PST meeting. Despite some individuals with intellectual disability requiring Phenytoin, the issue of using Phenytoin on an individual with intellectual disability should be justified in the PSP and on the drug review form. The individual was provided with a fiber supplement. The Facility must enhance its policies to reflect the actual process for monitoring new medication orders, roles and responsibility of staff, documentation practice, remedial action. The Facility must ensure that the pharmacist documents appropriate rationale and follow-up issues related to each intervention. o The Individual was provided Alendronate for "osteoporosis." The drug review form did not comment on the use of Alendronate on a male Individual. The FDA has approved alendronate for osteoporosis in males. However, for all individuals, including males, there must be a comprehensive evaluation as to the cause of the low bone density. Prior to administering alendronate, a male patient must be evaluated for underlying conditions, such as hypothyroidism, hypogonadism, and other important conditions; the Monitoring Team did not see documentation this was done. Also, because of the potential for serious side effects, such as osteonecrosis of the jaw and the more recent concern of spontaneous fractures of the femur, the PST must be actively aware of the use and on-going monitoring of this medication. • Individual #188 The individual was noted to have seizure disorder and on Phenobarbital, Topiramate and Phenytoin. The individual was noted to have five observed seizures during the previous quarter. Prior 12 months of fluctuating Phenytoin levels was not commented on in the report. Significant fluctuations in drug levels must be noted in the PSP and on the drug review form, which was not the case. Enhanced monitoring for side effects was not noted to be ordered. The individual was noted to have constipation and the drug review form commented that the individual was prescribed two medications for constipation: "MiraLax and Lubiprostone" and that the individual required the use of "Bisacodyl 3 times in Q4 of 2010." The pharmacist provided no	

#	Provision	Assessment of Status	Compliance
		recommendations. Importantly, the individual was also prescribed a fiber supplement, Fiber-stat laxation liquid. The Facility must enhance its policies to reflect the actual process for monitoring new medication orders, roles and responsibility of staff, documentation practice, and remedial action. The Facility must ensure that the pharmacist documents appropriate rationale and follow-up issues related to each intervention. • Individual #654 o Individual was on multiple medications for Seizure disorder and despite polypharmacy and implantation of Vagal Nerve Stimulator (VNS), the individual experienced worsening seizure frequency. No clinical rationale was postulated by the pharmacist as to why the individual may be experiencing additional seizures, such as potential drug interaction with fiber supplement, possibility of missed doses or failure to ingest the medications. Also, individuals must receive adequate hydration when provided fiber supplementation. o The individual was also provided iron supplement for Iron deficiency anemia. The QDRR did not comment on the etiology of the iron deficiency anemia. It is critical that the etiology of iron deficiency be well explored. The clinical pharmacist, in participating as an active member of the clinical team, should identify this issue as one needing further review. o The Individual was prescribed nasal calcitonin for "osteopenia." The drug review did not justify or even comment on the use of long term nasal calcitonin in persons with intellectual disabilities. The individual also received vitamin D for the Diagnosis of "osteoporosis" and the Pharmacist did not comment on the two different diagnoses. Following its review of Provision N.2, because of lack of comprehensiveness and completeness of the QDRRs, the Monitoring Team has determined that the Facility remains non-compliant with the Provision.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner,	To assess compliance for Provision N.3, the Monitoring Team conducted a meeting with the Director of Pharmacy, reviewed the minutes by the Pharmacy and Therapeutic Committee, and reviewed the following documents: Restraint Checklist, Face-to-Face Assessment form, and Restraint Documentation Guidelines for State Supported Living Centers, dated November 2008, and the Positive Behavior Support Limitation of Restraint as a Crisis Intervention policy and procedure, dated 11/5/2009. During the past 12 Months, the Facility had made improvements in the use of benzodiazapines, anticholinergic medications, and polypharmacy. The use of STAT medications for crisis intervention had also improved. Since October 2010, the Facility	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	reported the use of only one STAT medication, which was reviewed through the P&TC. The use of STAT medications was reported to be tracked longitudinally and reviewed at the P&TC. Although the Polypharmacy Committee reviews the use of psychotropic medications, the Pharmacy Director reported that they do not specifically address the use of benzodiazapines or anticholinergic medications, nor do they have a mechanism in place to actually track data and review outcomes. According to the Pharmacy Director, there were no policies that specifically addressed a comprehensive assessment of benzodiazapines and anticholinergics. There was no policy to address metabolic syndrome. Although the Pharmacy Director reported that certain variables, such as blood pressure, weight, glucose and lipid monitoring are assessed at the time of the QDRR, following review of QDRRs and the active clinical records for individuals #605, #119, #178, #496, #452, #395, #765, #201, #310, #279, 567, #341, #620, the Monitoring Team did not observe a systematic process that employs standard of care practice to monitor for this syndrome. A specific policy should be in place that delineates the exact parameters to monitor, including abdominal girth, the frequency required for monitoring, and how to manage abnormal results form the screening process. Importantly, the PST must be actively involved in this process. Because the Facility did not specifically monitor for metabolic syndrome, per standard of care protocol, did not specifically monitor the use of benzodiazapines and anticholinergic medications, or maintain a specific database for trends analysis of their use, nor demonstrate a trends analysis for the use of STAT medications, the Monitoring Team concurs with the Facility's assessment and has determined that the Facility is not in compliance with provision N.3 of the Settlement Agreement.	
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.	Information to assess compliance for Provision N.4, was derived solely from the Director of Pharmacy. The Facility did not have specific policies, procedure or guidelines to address this issue. Pharmacists provide notification regarding clinical maters to physicians via email, telephone, Quarterly Drug Review form, adverse drug reaction form, drug intervention form and direct person-to-person contact. Following review of provision N.1 and N.2, the Monitoring Team raised issues with the quality of pharmacists' notification of clinical issues (please refer to Provisions N.1 and N.2). This process must continue to be enhanced. Physician response to Pharmacists recommendations cannot simply state, "continue to monitor" or "benefit outweighs risk.." The Pharmacist cannot accept such responses as valid. The physician must provide a	Noncompliance

#	Provision	Assessment of Status	Compliance
		clinically rational explanation that the pharmacist concurs with. In the event that the pharmacist does not concur with the physician's response, clinical leadership must be notified to address concerns. Clear policy and procedure must be developed to address physician–pharmacist participation in any pharmacy review or intervention. As a clinical practitioner, the Pharmacist is responsible for adverse outcomes secondary to treatment. The Director of Pharmacy and Medical Director should meet regularly to discuss compliance issues and outcomes related to Pharmacist-Physician collaboration. Secondary to the lack of comprehensive recommendations by pharmacists, and the physicians continuing to use the terms "will continue to monitor" and "the benefits outweigh risks" without providing appropriate clinical rationale, the Monitoring Team agrees with the Facility and has determined non-compliance with Provision N.4 of the Settlement Agreement.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	To determine compliance for Provision N.5, the Monitoring Team conducted a meeting with the Facility's Pharmacy Director; reviewed clinical records of Individuals #605, #119, #178, #496, #452, #395, #765, #201, #310, #279, 567, #341, and #620; reviewed 12 Months of laboratory data, six Moses, six Months of medication records, and DISCUS reports for individuals #605, #232, #540, #127, #423, #669, #494. • Individual #605 had MOSES and DISCUS reports appropriately completed as scheduled. No issues were noted by the Monitoring Team. • Individual #232 had MOSES and DISCUS reports appropriately completed as scheduled. No issues were noted by the Monitoring Team. • Individual #540 had MOSES and DISCUS reports appropriately completed as scheduled. No issues were noted by the Monitoring Team. • Individual #669 had MOSES and DISCUS appropriately completed timely. No issues were noted by the Monitoring Team. • Individual #217 had MOSES and DISCUS completed timely; however, two of the reports did not have the prescriber review portion completed by the physician. No additional monitoring per MOSES, DISCUS or by clinical observation were provided outside of the scheduled assessments. • Individual #494 had MOSES and DISCUS completed timely; however, two of the reports did not have the prescriber review portion completed by the physician (DISCUS reports 12/06/10 and 09/10/10). • Individual #423, as reported at the time of requesting MOSES and DISCUS reports, did not have a DISCUS, because "he does not take psych meds.. " The individual did take non-psychiatric medications that must be monitored. No formal monitoring for side effects to medications was provided to this individual. Although this provision specifically refers to monitoring of TD, the Monitoring Team would like recommend strongly that the Facility also monitor	Noncompliance

#	Provision	Assessment of Status	Compliance
		side effects of all medications. The Director of Pharmacy reported to the Monitoring Team that the Facility did not have a policy or formal process to ensure competency based training for physicians, pharmacists, nurses or psychologist on the use of the DISCUS or MOSES, or for routine clinical observation for side effects. Also, there was no formal process in place to conduct inter-rater reliability assessments for those who perform or review the MOSES and DISCUS assessments. Importantly, the Facility did not have a policy or effective process in place for monitoring tardive dyskinesia or other medication side effects outside of the use of the MOSES and DISCUS. When ever there is a psychotropic medication change, discontinuation of a medication, addition of a medication, dose change or change in clinical condition, all staff who work closely with the individual must be aware to closely monitor the individual and reported observational changes to the nurse and physician. All DISCUS reviewed by the Monitoring Team for Provision N.5, had a total score of 0, despite people having risk factors for movement disorders such as being on intraclass polypharmacy, prolonged use of psychotropic medication, and history of use of typical antipsychotic medications. During subsequent reviews, the Monitoring Team will conduct inter-rater reliability assessments based of observations of individuals and completed assessments. Severe potential and realized side effects must be incorporated into the team process and reported in the PSP. Review of active clinical records of Individuals #605, #119, #178, #496, #452, #395, #765, #201, #310, #279, 567, #341, #620, did not demonstrate effective consideration by the Team of side effect issues. As a result on failure to complete prescriber reviews, lack of appropriate training on the use of DISCUS and MOSES, lack of inter-rater reliability assessments for those how perform and use the DISCUS and MOSES, lack of an effective mechanism to closely monitor individuals for side effects by all staff who work closely with individuals, and no significant indication that individuals are monitored for signs of tardive dyskinesia outside of their scheduled DISCUS and MOSES, The Monitoring Team concurs with the Facility's assessments and has determined that the Facility is not in compliance with Provision N.5. Furthermore, the Monitoring Team suggests that the Facility must monitor side effects of all medications; one way to do so is to use the MOSES side effect scale to monitor persons on non-psychotropic medications as well as to ensure staff are aware of and alert to changes in conditions that should be reported as possible side effects.	
N6	Commencing within six months of	The Monitoring Team discussed the issue of Adverse Drug Reactions (ADRs) with the	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Pharmacy Director, reviewed three ADRs that were reported since October and reviewed the policy and related forms on ADRs – Processes for Adverse Drug Reaction Reporting, dated 7/26/10. Following review of the Facility's policy for ADRs, the Monitoring Team noted that there was no provision on the type of medical assessments by the physician or duration of clinical monitoring by the nurse and direct care staff, following an adverse drug reaction. The policy was devoid or procedures for or guidance on notifying the PST and the legally responsible person of an ADR or suspected ADR. The Policy did not delineate the need for routine competency based training for all staff, including direct care, physicians, pharmacists, psychologists, nurses and other staff who work closely with individuals, on the ADR process. Per discussion with the Pharmacy Director, the Monitoring Team concurs with her observational assessment in that the Facility has an extremely low rate of ADR reports, hence, potential under-reporting of ADRs. ADRs must be longitudinally tracked and periodic analysis performed per the P&TC or other responsible committee at the Facility. There was no formal mechanism in place to maintain and review data on ADRs. The Monitoring Team concurs with the Facility's assessment and determines non-compliance with Provision N.6, of the Settlement Agreement. The Facility must immediately address its process on identifying, assessing and following up on adverse drug reactions.	
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.	To assess compliance for Provision N.7, the Monitoring Team conducted a meeting with the Director of Pharmacy, reviewed the two Drug Utilization Evaluations (DUE) completed by the Facility and the Facility's process for DUEs, as outlined by the "Review Processes for Drug Utilization Evaluation", dated November, 12, 2010. The process, as outlined, was comprehensive and followed the direction of standard DUE format; however, the P&TC should provide rationale as to why a particular drug or drug class is chosen and priorities listed for future DUEs. Also, there should be a mechanism to provide immediate DUEs based on drug warnings issued by the Federal Drug Administration. The process, as outlined in the Review Processes for Drug Utilization Evaluation, gives the impression that the benefit of a DUE is for physicians only. This fact is demonstrated in steps 4, 6, 7, and 8 of the Review Processes for Drug Utilization Evaluation, which comments only on how data is to be " a proportional distribution of physicians who	Noncompliance

#	Provision	Assessment of Status	Compliance
		prescribe the medication"; "the P&T Committee shall interpret the aggregate data to identify primary care physicians and systemic patterns and trends and shall make recommendations for actions as indicated"; and "The Medical Director Shall address any outlying trends of individual Primary Care Physicians with educational interventions aimed at improving performance.". Although this is one important outcome of a DUE, a DUE has many other outcomes that may involve all staff providing direct services to individuals served and non-staff related issues, such as FDA warnings and practice changes in dispensing, and administration of the medications. The Facility did not have a mechanism in place to follow-up on recommendations to assess outcome trends following a DUE. It is critical that the Facility periodically monitor effectiveness of the DUE, longitudinally. Enhanced training venues for appropriate staff, geared at their level of expertise, is another important component of a comprehensive DUE process. The number and frequency of DUEs should be assessed. There are a significant number of medications that have narrow toxicity levels, associated with significant adverse reactions and have potential for adverse outcomes that should be reviewed by the Facility. The Warfarin DUE, conducted in July of 2009 was exemplary with regards to drug determination, data collection, data analysis and recommendations. The Dilantin DUE was incomplete and provided nothing more then a list of individuals who were prescribed Dilantin, a one-page summary of the recent literature and a recommendation to "Recommend Free Dilantin Levels". There was no summary of potential issues regards to the Facility's practice, no trends data on use, no discussion of potential or known adverse outcomes, and no recommendation for training of staff or follow-up to demonstrate improved outcomes following the DUE. The Monitoring Team has determined that the DUE process, as presented, is a good start at developing and implementing a DUE process at the Facility. Enhancement in the process as delineated above will be necessary before the Monitoring Team can determine compliance with Provision N.7.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial	Provision N.8 was assessed by a meeting conducted with the Director of Pharmacy, requesting all policies and procedures associated with medication variances, review of P&T minutes, dated November 15, 2010, "Med Order Variance" report, dated 12/26/10, and New Medication Order Review document, dated October 18, 2010. The current system for reporting, monitoring, assessing and enhancing processes of	Noncompliance

#	Provision	Assessment of Status	Compliance
	action regarding actual and potential medication variances.	medication variances was fragmented throughout the Facility. Nurses conducted their own internal medication variance process and report to the P&TC. The Pharmacy Department monitored "new medication orders" and dispensing issues. There was no reported participation on the part of physician services. Pharmacy did not have any specific policies that address medication variances, with the exception of reviewing new orders. Comprehensive data collection and analysis on medication variances did not occur. A functional, meaningful medication variance program involves an organized structure that consists of all relevant professionals, including nursing, pharmacy and physician services. Because of their central role and ability to closely monitor medications, the Pharmacy Department generally is responsible for a medication variance program. A medication variance program must include the following areas: 1. Storage and handling variance – such as security, temperature, humidity, expiration dates. 2. Dispensing variances 3. Prescribing variances – including non-legible/non-complete scripts 4. Administration variance Some medication variance programs also include failure to appropriately monitor for side effects and other adverse reactions. The Facility must develop and include in its medication variance program a process to provide remedial action for variances. Based on discussion with the Pharmacy Director, fragmenting of the various responsibilities of the medication variance process, non-involvement of physician staff, lack of comprehensive data collection, no formal policies for a comprehensive medication variance program, lack of formal policy and process on providing remedial action for medication variances, the Monitoring Team has determined that the Facility remains non-compliant with Provision. N.8, of the Settlement Agreement.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:
1. The Facility must enhance its policies to reflect the actual process for monitoring new medication orders, roles and responsibility of staff, documentation practice, and remedial action. The Facility must ensure that the pharmacist documents appropriate rationale and follow-up issues

related to each intervention.

2. When providing bisphosphonates for a non-FDA indication it is essential that the PST, including the legally responsible person, be made aware of its use and the potential risks, including osetonecrosis and spontaneous fractures of the femur.

3. The quality of QDRRs must be enhanced.

4. The use of phenobarbital and phenytoin at the Facility must be closely monitored. When clinically appropriate, an attempt to minimize such medications is prudent. When an Individual can not be discontinued from either of these medications, clear rationale in the PSP and clinical record.

5. Immediately develop specific policy to address the use of benzodiazapines, and anticholinergics.

6. Immediately develop and implement a policy for metabolic syndrome.

7. Develop a specific tracking system, preferably a database, to monitor STAT medications, benzodiazapines and anticholinergics.

8. Develop a specific policy, and enhance communication forms specific to physicians' response to pharmacists' recommendations. Pharmacists and physician participation in this process must also be enhanced. The Director of Pharmacy and Medical Director should conduct a regular documented meeting to discuss issues related to physician and pharmacists collaboration.

9. Immediately ensure that prescribers complete MOSES and DISCUS reports.

10. Immediately develop a mechanism to perform competency based training for all staff who perform or rely on the MOSES and DISCUS reports. This includes pharmacists, nurses, psychologists and physicians.

11. Immediately develop a comprehensive medication variance review process, as outlined in Provision N.8.
12. The Facility should develop standard of care practices to closely monitor Individuals who are prescribed any class of medication.

13. Ensure that inter-rater reliability checks are done periodically and involve each person who performs MOSES and DISCUS assessments.

14. Potential and realized side effects to medications, especially when severe, must be better incorporated into the team process and well reported in the PSP.

15. Develop a system to provide routine competency based training for all staff, including physicians, nurses, psychologists, pharmacists, and others who work closely with individuals on the ADR process.

16. Enhance the ADR Policy to include on-going physical assessment by the physician and monitoring by the nurse and other staff who work closely with the individual. The policy should delineate the need for competency based training

17. Advise staff on the importance of monitoring and reporting of ADRs and foster an environment that will enhance reporting of ADRs at the Facility.

18. Enhance the current DUE process, as delineated in Provision N.7.

The following are offered as additional suggestions to the facility:

1. DADs may consider developing a more unified approach to DUE's by centralizing the process.
2. The routine use of the MOSES side effect scale must be provided to all individuals who take medications, not only psychotropic medications.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. DSSLC Plan of Improvement, (POI) 03/15/2011 2. Records reviews for: Individuals #131, #181, #201, #218, #245, #272, #336, #401, #419, #519, #537, #548, #578, #580, #699, #758, #761, #776, and #781 3. Integrated risk reviews for individuals #131, #181, #201, #218, #245, #272, #336, #401, #419, #519, #537, #548, #578, #580, #699, #758, #761, #776, and #781 4. OT/PT assessment reviews and PNMPs for Individuals #131, #138, #178, #181, #201, #218, #245, #272, #336, #401, #419, #511, #519, #537, #548, #563, #567, #570, #578, #580, #620, #669, #699, #726, #758, #761, #766, #776, and #781 3. A list of all therapy and/or clinical staff (OT, PT, SLP, RD,), and Physical and Nutritional Management (PNM) team members, including credentials 4. Policies, procedures, and/or other documents related to Physical and Nutritional Management (DADS Policy #012.2 dated 3/21/2011) 5. Curriculum vitae (CVs) for PNMT members 6. A list of continuing education sessions or activities participated in by PNMC members since 1/2010 7. Minutes, including documentation of attendance, for the following meetings • PNMC meetings (9/2010 to 3/2011) • PNMT meetings (9/30/10 to 2/17/11) 8. Individual PNMPs for individuals reviewed above 9. Health Risk screening forms (Skin Integrity, Injury, Aspiration) used to 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. PNM Target List 13. A list of PNM assessments and updates completed in the last two (2) quarters 14. Tools used to monitor implementation of PNM procedures and plans 15. A list of individuals for whom PNM monitoring tools were completed in the last quarter 16. Tools utilized for validation of PNM monitoring 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: (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 21. Suction Toothbrush checklist 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 **People Interviewed:** 1. Donna Groves, OTR (Director of Habilitation Services) 2. Frank Padia, Director of Program Coordination 3. Six DCPs Cedar Falls **Meetings Attended/Observations:** 1. PNMT meeting 3/28/11 2. Observations of mealtimes on Cedar Falls 3. Life skills Areas-Cedar Falls
	Facility Self-Assessment: For Provision O.1, the Facility stated they are not in compliance with this provision. DSSLC stated that since the last compliance review (9/2010) a Physical and Nutritional Management Committee (PNMC) has been formed and the PNMC has been at work on developing clinical pathways for aspiration pneumonia, training had begun for Aspiration Triggers Data Sheet, and the data sheet was implemented. For Provision O.2, the Facility stated they are not in compliance with this provision. DSSLC stated that 34 individuals receiving enteral nutrition had been provided with evaluations.

	For Provision O.3, the Facility stated they are not in compliance with this provision. DSSLC stated that statements regarding positioning for oral care and medication administration were added to PNMPs. Additionally, meetings have been held with medical, pharmacy, and nursing to discuss medication administration for individuals on ground or pureed diets. For Provision O.4, the Facility stated they are not in compliance with this provision. DSSLC stated that positioning alternatives such as carefoam chairs and Aro hospital beds were being reviewed for potential trials. For Provision O.5, the Facility stated they are not in compliance with this provision. DSSLC stated that staff was trained annually on PNMP concepts and individual specific training was provided to staff during On the Job training. For Provision O6, the Facility stated they are not in compliance with this provision. DSSLC stated that a new comprehensive PNM monitoring form was developed. Additionally, plans were developed by multidisciplinary meal groups in an effort to improve mealtime. For Provision O.7, the Facility stated they are not in compliance with this provision. DSSLC stated that Habilitation Therapies (HT) met with QA to review monitoring procedures and outside sources are being reviewed to develop a comprehensive monitoring policy. For Provision O.8, the Facility stated they are not in compliance with this provision. DSSLC stated that an Aspiration Pneumonia-Enteral Nutrition Evaluation was implemented and all individuals receiving enteral nutrition had received the evaluation. In addition, DSSLC noted that 17 individuals with enteral feedings have returned to some form of oral intake. The self-assessment of noncompliance in all sections was consistent with the monitoring team's assessment of noncompliance with this provision.
	Summary of Monitor's Assessment: **Provision O.1:** This provision was determined to be not in compliance. A Physical and Nutritional Management Team (PNMT) had been formed as well as a Physical and Nutritional Management committee (PNMC). The PNMT focused more on clinical issues and assessment and served as a resource to the PST. The PNMC focused more on systems issues. A process that outlines the responsibilities of both teams as well as their scope had not yet been developed. There was still no evidence that data are collected and the team is reviewing these data to better identify system issues or respond to recurrent issues on a regular basis. The PNMT meeting attended by the monitoring team was impressive in that there was active collaboration between not only all members of the PNMT but the PST as well. The issue lies that unless the PNMT is referred to, there is little to no response to changes in status by the PST.

	Provision O.2: This provision was determined to be not in compliance. A new risk policy and procedure was in the process of being implemented to address the need to more accurately identify an individual's risk. While this new process was much improved and risk level was accurately identified for more people, the risk process was not consistently implemented correctly. Additionally, supports regarding the areas of oral care and medication administration were not comprehensive and lacked detail on the PNMP. Based on a review of 29 individuals' OT/PT assessment (11 of which were completed within the past month), 22 of 29 Individuals were not provided with a comprehensive assessment by the PNM team or PST that focused on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake. **Provision O.3:** This provision was determined to be not in compliance. 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. An improvement was noted with alternate positioning (i.e., positioning in wheelchairs and recliners. DSSLC has done a remarkable job with developing seating supports that allow individuals the opportunity to utilize recliners as part of their daily positioning schedule. Other positive notes regarding the PNMPs were that information regarding transfers, adaptive equipment, and strategies for moral intake were noted to be clearly written and were supportive in reducing the individuals risk during these activities. **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 not provided with safe dining strategies. 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 had just recently revised the monitoring form so that it would cover all aspects in which the individual was determined to be at increased risk. A formal process and data system had not yet been developed. **Provision O.7:** This provision was determined to be not in compliance. There was not a formal monitoring process in place that clearly defined how the monitoring process would be maintained or implemented. DSSLC was in the process of implementing an Aspiration Trigger Data Sheet that will monitor clinical

	indicators relevant to aspiration on a daily basis. This is a positive step as this will help develop a more proactive response to potential issues. There is a need, however, to expand this tracking to all individuals at increased risk and not only those who have had an aspiration pneumonia in the past year. **Provision O.8:** This provision was determined to be not in compliance. An Aspiration Pneumonia/enteral Nutrition evaluation was developed which was a positive step. The issue was that the Evaluation is completed as more of a review and does not investigate root cause of the issue resulting in hospitalization. Additionally, pathways to PO (by mouth) status and the implementation of oral motor strategies to improve oral control and maintenance were consistently not implemented or identified. Overall, DSSLC has shown improvements in several areas, from the active collaboration of the PNMT to the brainstorming of the team to address the reinventing of positioning standards when utilizing recliners as an alternate option for positioning.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff,	DSSCL had a Physical and Nutritional Management team. Based on review of minutes and/or assessments, the PNMT served as a resource to the PST should the PST feel they have run out of options and are in need of additional assistance. The team met at a minimum monthly and as indicated by team referral. While the team was more comprehensive than during the previous visit, as demonstrated by increased participation by relevant team members. the team still did not consist of a qualified SLP. The team lacked a Speech Pathologist due to lack of available staff. DSSLC also formed a Physical and Nutritional Management Committee whose primary role was to look at systems issues. This team met monthly. It consisted of core members OT Director, Medical Director CNE, PT, Dentist, QA, Unit Director, and CTD Assistant Director. Adjunct membership included but was not limited to infection control and wound care nurse, and Director of Pharmacy. Again, due to lack of availability, a SLP was not part of the team. Based on a review of PNM Team attendance records and meeting minutes from 9/30/2010 to 2/17/2011 and PNMC minutes from 11-2010 to 2-2011, there was no participation by the Speech Pathologist (SLP) in any of the meetings Review of PNM clinical instruction documentation submitted revealed that PNM Team members had training and professional development in the following areas: • In three of three individual clinical instruction records reviewed, continuing education related to physical and nutritional supports had been provided	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	within the last 12 months. Based on a review of 19 individual records, documentation supported that the PNM 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 Team or PST did not meet regularly to address change in status included: • Individual #245 developed aspiration pneumonia on 10/26/10 but there was no evidence that the PNMT or PST met to discuss to discuss the aspiration post-hospitalization. • Individuals #131 and #548 had a modified barium swallow study conducted on 12/21/2010. There was no evidence that the PST or PNMT met to discuss the findings of the test and determine if there was a need to revise the current plan of care • Individual #537 had a choking event occur on 1/14/2011 post visit to have teeth extracted. There was no evidence of discussion prior to return to home regarding whether diet texture should be temporarily modified. Additionally, there was no evidence that the PST met to discuss findings of a meal observation that occurred on 1/14/11. • Individual # 761 had a choking event on 11/15/10 but there was no evidence of PNMT or PST discussion or evaluation of the event outside of the incident report. • Individual # 419 developed aspiration pneumonia on 11/5/10. The team met to discuss the hospitalization but there was no evidence that the PNMT or PST met to discuss the findings of the MBSS that was conducted on 11/18/10 • Individual #699 developed aspiration pneumonia on 12/10/2010 but there was no evidence that the PNMT or PST met to discuss issues until the PSP meeting on 1/14/11. The PST did not meet post hospitalization to discuss the aspiration event. There was no facility PNMT process that clearly outlines their responsibilities as well as criteria for referral. Per interview with the Habilitation Director, DSSLC was in the process of modifying the state policy. Additionally, there was no process that covered the responsibilities of the PNMC. As evidenced by team notes, the PNM team met 39 times over the past 3 months This type of collaboration represents a true interdisciplinary process. The practice of having active collaboration between PNMT and PST teams triggers comprehensive problem solving that will assist the teams in developing a more proactive approach to treatment.	

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		The PNMC met three times since November 2010. The primary focus of the PNMC has been to develop a flow sheet that would consolidate menses, BM tracking and intake.	
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 19 Integrated Risk Reviews for individuals on the DSSLC Target List accurately identified individuals who are at an increased risk of physical and/or nutritional decline. Examples of individuals not being appropriately identified include: • Individuals #218, #245 and #758 had aspiration pneumonia within 3 months of this review but none were listed as being at a high risk as recommended by the state guidelines. • Individual #580 had seven falls occurring from 1/7/11 to 2/3/11 and had a choking event occur on 11/24/10 but was not listed as being at "High Risk" in either category. • Individuals #761, #537, #181, had recent choking events (within the past 3 months) but were not listed as "high risk." Although, the numbers above may not reflect themselves as such, this was a substantial improvement from the previous compliance visit that occurred in September 2011. Based on a review of 29 individuals' OT/PT assessment (11 of which were completed within the past month), 22 of 29 Individuals were not provided with a comprehensive assessment by the PNM team or PST that focused 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 #537 OT/PT assessment (2-11) states the individual demonstrates rotary chewing but did not describe spillage, pocketing, or residue or the lack there of. • Individual #726's OT/PT assessment (2/17/11) stated the individual has vertical chewing and tongue mashing but did provide the functional relevance of these issues. • Individual #563's OT/PT assessment stated the person had poor oral motor skills but did 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 19 records involving individuals revealed:	Noncompliance

#	Provision	Assessment of Status	Compliance
		• In zero of the 19 records reviewed (0%), there was 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 or medication administration in a comprehensive manner. The PNMPs were not comprehensive, as they did not contain detailed information regarding oral care as the plans simply stated the type of toothbrush utilized but did not contain strategies or methods on how to provide the service. While medication administration was listed on the PNMPs, it was not comprehensive, as it did not state the amount or number of pills the individual could safely tolerate. While the implementation of suction toothbrushing is a huge step forward in addressing the risk of bacterial and aspiration pneumonia; the implementation was generic in nature and not individualized. There was no individualization occurring with regards to implementation. Additionally, the toothbrushing checklist stated that individuals who had aspiration tendencies should not be provided with water, toothpaste, or mouthwash during suction toothbrushing. The use of no water and no toothpaste contradicts the reasoning behind implementing suction tooth brushing. 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. Lack of such a system increases the likelihood of issues not being addressed on a systemic level. It was the hope of DSSLC that the PNMC would begin to address this area in the future.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing	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 and specifics regarding head of bed elevation. For example: Based on a review of 29 individual PNMPs, individuals were not provided with a comprehensive PNMP. o In 21 of 29 PNMPs reviewed (72%), strategies for medication administration were not included. o In 29 of 29 PNMPs reviewed (100%), strategies for oral hygiene were not included. o In 29 of 29 PNMPs (100%) did not contain the degree in which the person should be elevated. Including the degree of head of bed elevation is important as it allows the information	Noncompliance

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	difficulties.	regarding head of bed elevation to be easily transferrable to an off grounds location (i.e., hospital, community setting). Currently, the PNMP states only that the head of bed is elevated and staff relies on chains attached to the bed. This is a reliable method and helps remove the guesswork at the facility but does not translate well to other settings. Oral Care and Medication Administration were included in the PNMP but lacked detail regarding number of pills that can be safely tolerated at one time and strategies on how to assist during oral care. There were, however, several positive practices that the Facility should ensure continue. o In 29 of 29 PNMPs reviewed, positioning instructions for wheelchair and alternate positions instructions were included as applicable. o In 29 of 29 PNMPs reviewed, transfer instructions were included as applicable. o In 29 of 29 PNMPs reviewed, the mealtime/dining plan included intake information for mealtime and snacks o In 29 of 29 PNMPs reviewed, the mealtime/dining plan included food/fluid textures as applicable. o In 29 of 29 PNMPs reviewed, the mealtime/dining plan included behavioral concerns related to intake. o In 29 of 29 PNMPs reviewed, individual adaptive equipment was included. o In 29 of 29 PNMPs reviewed bathing/showering positioning and instructions were included Additionally, An improvement was noted with alternate positioning (i.e., positioning in wheelchairs and recliners. DSSLC has done a remarkable job with developing seating supports that allow individuals the opportunity to utilize recliners as part of their daily positioning schedule. In 19 of 19 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. In 19 of 19 records reviewed (100%), PNMPs were reviewed annually at the PSP meeting.	
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	Staff did not consistently implement interventions and recommendations outlined in the PNMP and/or Dining Plan. Four of 12 observations (33%) demonstrated that staff implemented interventions and recommendations outlined in the PNMP and/or mealtime plan which were most likely to prevent swallowing difficulties and/or increased risk of aspiration in the following areas:	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• In four of 12 observations (33%), staff were following mealtime plans. • In 11 of 12 observations (92%), staff were following wheelchair positioning instructions. • In 12 of 12 observations (100%) staff were following alternate positioning instructions. Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan: • Staff were standing over Individual #347 with the staff's hands placed on the sides of the individual's mouth. The plan called for small bites and sips and verbal encouragement to eat. • Individual #310 was provided no encouragement from staff to hold cup. • Individual #741 was not provided with a small nosey cup. • Individual # 707 did not have his lap tray attached during mealtime • Individual #498 was not allowed time to swallow two times between bites. • Individual #746 was slid down in the chair resulting in increased abdominal compression. Based on interviews with six DCPs: • In six of six interviews with staff (100%), staff were able to identify the location of the PNMP and/or mealtime plan. • In three of six interviews with staff (50%), staff could individual-specific PNMP strategies. • In two of six interviews with staff (33%) , staff could describe the schedule for implementation of PNMP strategies. • In three of six interviews with staff (50%) , 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 it is important to assist at eye level when providing assistance during meals or oral care. • Staffs were not able to describe rationale for alternate positions other than to decrease risk of skin breakdown. 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	

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		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 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. Per interview with Director of Habilitation Services, 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 the POI, there was 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. Per interview with the Director of Habilitation Services, an annual PNM refresher was being developed and Transfers/Lifting was completed every two years unless there was a change in service or technique which then would be provided at the time of the change.	Noncompliance
O6	Commencing within six months of	A policy/protocol that addresses the monitoring process and provides clear direction	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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 form was in place to cover mealtime observations as well as a comprehensive PNM monitoring form that was being trialed that was designed to address mealtime as well as areas outside of mealtime. While the forms were designed to address mealtime and other pnm areas and had 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, • A requirement that monitors are re-validated on an annual basis by therapists and/or assistants and that inter-rater reliability checks are conducted to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitoring, and • Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician. There was also lack of data acquisition and analysis regarding the completion of the monitoring forms. As of this review, the PNMC was unable to pull information regarding the percentage of monitors completed or who had been monitored, as well as data aggregated by areas addressed by the PNM monitoring form. Per the Director of Habilitation Services, this was an area that needed to be developed and would be developed after the trial of the new monitoring form was completed. 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 PNMC was formed in November 2011 but there was no evidence they met regularly to respond to indicators identified by monitoring.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop	A process was not in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk. Based on the review of 19 individual records, the PNM Team or PST did not document	Noncompliance

#	Provision	Assessment of Status	Compliance
	and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	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 fully in place that clearly monitored the effectiveness of the plan by tracking clinical indicators for all individuals who are determined to be at a high risk such as the occurrence or absence of triggers (signs and symptoms associated with physical and nutritional decline that require staff response). The Aspiration Trigger data Sheet was in the process of being implemented for the individuals who were on the target list. The trigger data sheet was designed to monitor the presence or absence of triggers related to potential aspiration. The development of this data sheet is another positive step forward in better being able to identify signs and symptoms. The issue with the existing data sheet included: • Lack of individualized triggers • Lack of notification of all occurring triggers. For example, a trigger may not be documented or nurse notified if the trigger stopped occurring after repositioning or plan implementation. • Lack of implementation for all individuals who were identified as being "high risk." Collaboration with nursing improved response to care when a problem with skin integrity was identified. Once the Wound Care Nurse identified a concern with skin integrity, she made a referral to the Habilitation Therapy Department. The Wound Care Nurse explained that Habilitation Therapy "worked miracles" in changing positioning schedules, modifying wheelchairs, creating positioning apparatus, and ordering/providing specialty mattresses when indicated to assist individuals successfully heal.	
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	Based on the review of six individuals who were enterally nourished revealed these individuals did not receive an annual assessment that addressed potential pathways to PO status. The Aspiration Pneumonia/Enteral Nutrition Evaluations identified the medical necessity of the tube but did not provide information regarding potential pathways to oral intake. The section covering the area of attempts to return to oral intake includes information regarding current status but does not contain information regarding strategies to increase oral motor status. Additionally, there was a lack of root cause investigation. It is important that oral motor status be addressed through programming not only for the potential to return to oral intake but to improve the	Noncompliance

#	Provision	Assessment of Status	Compliance
	Facility shall implement a plan to return the individual to oral feeding.	individuals' oral status so that they can more safely manage secretions. Examples of individuals who received enteral nutrition and did not receive a comprehensive annual assessment focused on pathways to oral intake: • Individuals ##519, #336, #776, #245, #218 and #758. Six of Six individuals reviewed who received enteral nutrition and/or therapeutic/pleasure feedings were provided with a PNMP. This PNMP, however, was not comprehensive and was missing the same information as listed in Provision O.3.	

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

1. 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.
2. Ensure the policy and procedure for monitoring defines the process of analyzing monitoring reports and formulating corrective strategies to address specific and/or systemic areas of deficiency.
3. 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.
4. A formal process should be developed that ensures individuals who are at an increased risk receive more intensive monitoring.
5. 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.
6. 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).
7. 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. Information to be included as part of medication administration should be not only the texture of the pills but the number of pills the individual can safely tolerate.
8. The PST must meet in a timely manner in response to changes in status. This meeting should provide comprehensive problem solving and timely implementation.
9. Aspiration Pneumonia/Enteral Nutrition Evaluations should be expanded to focus on root cause of incident and do a better job providing assessment of the situation rather than just recalling the event and the current plan of care.
10. Aspiration Trigger Data Sheet should be expanded for all individuals who are at an increased risk and not just the individuals who are on the target list.
11. Aspiration Trigger Data Sheet should be modified to include triggers specific to the individual.
12. Suction Toothbrushing training should be reviewed and revised to allow for the use of small amounts of water and non-foaming toothpaste. The use of water and toothpaste will further aid in the cleaning of teeth and removal of bacteria.

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:** **Documents Reviewed:** 1. DSSLC Plan of Improvement, (POI) 03/15/2011 5. Records reviews for: Individuals #131, #181, #201, #218, #245, #272, #336, #401, #419, #519, #537, #548, #578, #580, #699, #758 ,#761, #776, and #781. 6. OT/PT assessment reviews for Individuals #131, #138, #178, #181, #201, #218, #245, #272, #336, #401, #419, #511, #519, #537, #548, #563, #567, #570, #578, #580, #620, #669, #699, #726, #758, #761, #766, #776, and #781 2. Direct Treatment reviews of Individuals # 275, #327, #351, #399, and #673 3. A list of all therapy and/or clinical staff (OT, PT, SLP, RD,), including credentials 4. Curriculum vitae (CVs) for PNMT members 5. Minutes, including documentation of attendance, for the following meetings • PNMC meetings (9/2010 to 3/2011) • PNMT meetings (9/30/10 to 2/17/11) 6. Individual PNMT reports for individuals reviewed above 7. Tools used to screen and identify individuals' PNM health risk level. 8. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order. 9. Tools used to assess PNM status and needs. 10. A list of PNM assessments and updates completed in the last two (2) quarters. 11. PSPs for the individuals on the list above for whom PNM assessments and updates have been completed in the last quarter. 12. Completed Physical Nutritional Management Plans (PNMPs) for individuals with identified needs included in the sample. 13. Tools used to monitor implementation of OT/PT procedures and plans. 14. A list of individuals for whom OT/PT monitoring tools were completed in the last quarter. 15. 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. 16. Nutritional management plan template and any instructions for use of template. 17. Dining Plan template. 18. 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 19. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation during the past year. 20. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials. 21. Tools and checklists used to provide competency-based training addressing: (c) Foundational skills in PNM; and (d) Individual PNM and Dining Plans. 22. For the prior 12 months, a list of competency-based training sessions addressing foundational skills in PNM. 23. Information on percent of staff with responsibilities for the provision of direct supports who have completed competency-based training on foundational skills in PNM. **People Interviewed:** 1. Donna Groves Habilitation Director 2. Four DCPs Cedar Falls **3.** Three DCPs Houston Park **Meetings Attended/Observations:** 1. PNMT meeting 3/28/11 2. Observations of mealtimes on Cedar Falls 3. Life skills Areas-Cedar Falls
	Facility Self-Assessment: For Provision P.1, the Facility stated they are not in compliance with this provision. DSSLC stated that the therapists are consistently including expanded oral care/dysphagia information, medication administration, and positioning regarding bathing, and head of bead elevation. For Provision P.2, the Facility stated they are not in compliance with this provision. DSSLC stated Supported Visions training was implemented that included expansion and increased participation in the Personal Support Team (PST) process. For Provision P.3, the Facility stated they are not in compliance with this provision. DSSLC stated that staff was trained annually on PNMP concepts and individual specific training was provided to staff during On the Job training.

	For ProvisionP.4, the Facility stated they are not in compliance with this provision. DSSLC stated that a comprehensive monitoring tool was developed that will monitor multiple aspects of PNM concerns during one monitoring event. The self-assessment of noncompliance in all sections was consistent with the monitoring team's assessment of noncompliance with this provision.
	Summary of Monitor's Assessment: **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. Individuals not receiving direct services were not consistently reviewed by OT/PT should there be a change in status, An improvement was noted with regards to documentation regarding progress of individuals who were receiving direct OT/PT services. Notes were clearly documented through the use of an initial note, weekly note, and discharge note. **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 individuals at increased risk receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional	The facility provided an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience. There were eight Occupational Therapists, eight Certified Occupational Therapy Assistants, five Physical Therapists and an open position for a Physical Therapy Assistant. Based on a review of CVs for each therapy clinician, the Department did document appropriate qualifications for licensed OTs, PTs, and assistants.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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 review of OT/PT tracking spreadsheet, all individuals had received an OT/PT assessment and/or screening. This was validated via review of 29 records for completed OT/PT assessment/screening, including those who were admitted within the last 12 months. Assessment/screening indicated whether or not the individual required OT/PT supports and services for 29 of 29 records reviewed (100%). If receiving services, direct or indirect, five of five individuals (100%) were provided 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 OT/PT assessment was not comprehensive, as the Oral Motor components were lacking in detail, and did not provide sufficient information to be considered an assessment. For examples, refer to Provision O2. This area has shown improvement with the more recent evaluations but these still lacked the detail and objective measurements that permit comparative analysis. Based on a review of 19 individual records, documentation supported that the PNM 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 Team or PST did not meet regularly to address change in status included: • Individual #245 developed aspiration pneumonia on 10/26/10 but there was no evidence that the PNMT or PST met to discuss to discuss the aspiration post-hospitalization. • Individuals #131 and #548 had a modified barium swallow study conducted on 12/21/2010. There was no evidence that the PST or PNMT met to discuss the findings of the test and determine if there was a need to revise the current plan of care • Individual #537 had a choking event occur on 1/14/2011 post visit to have teeth extracted. There was no evidence of discussion prior to return to home regarding whether diet texture should be temporarily modified. Additionally, there was no evidence that the PST met to discuss findings of	

#	Provision	Assessment of Status	Compliance
		a meal observation that occurred on 1/14/11 • Individual # 761 had a choking event on 11/15/10 but there was no evidence of PNMT or PST discussion or evaluation of the event outside of the incident report. • Individual # 419 developed aspiration pneumonia on 11/5/10. The team met to discuss the hospitalization but there was no evidence that the PNMT or PST met to discuss the findings of the MBSS that was conducted on 11/18/10 • Individual #699 developed aspiration pneumonia on 12/10/2010 but there was no evidence that the PNMT or PST met to discuss issues until the PSP meeting on 1/14/11. The PST did not meet post hospitalization to discuss the aspiration event.	
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. 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 29 individuals, equipment was specified for 29 of 29 plans (100%) reviewed. Five of five individuals receiving direct services (100%) were consistently reviewed by OT/PT and documented through the use of an initial note, weekly note, and discharge note. This is a significant improvement since the previous visit when notes were not included as part of the IPN. The issue with the current process of integrating OT/PT direct therapy notes into the IPN was that notes are developed outside of the IPNs and then provided to file clerks at the end of the month. Lack of utilizing the actual IPN results in an increased likelihood that notes may be delayed. Individuals not receiving direct services were not consistently reviewed by OT/PT should there be a change in status. Refer to Provision O.1 for additional information.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 were observed not implementing recommendations identified by OT/PT. Four of 12 observations (33%) demonstrated that staff implemented interventions and recommendations outlined in the PNMP and/or mealtime plan which were most likely to prevent swallowing difficulties and/or increased risk of aspiration in the following areas: • In four of 12 observations (33%), staff were following mealtime plans. • In 11 of 12 observations (92%), staff were following wheelchair positioning instructions. • In 12 of 12 observations (100%), staff were following alternate positioning instructions. Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan: • Staff were standing over Individual #347 with the staff's hands placed on the sides of the individual's mouth. The plan called for small bites and sips and verbal encouragement to eat. • Individual #310 was provided no encouragement from staff to hold cup. • Individual #741 was not provided with a small nosey cup • Individual # 707 did not have his lap tray attached to mealtime • Individual #498 was not allowed time to swallow two times between bites • Individual #746 was slid down in the chair resulting in increased abdominal compression. 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. Based on interviews with ten direct support professionals: • In seven of seven interviews with staff (100%), they were able to identify the location of PNMP and/or mealtime plan. • In four of seven interviews with staff (57%), staff could describe individual-specific PNMP strategies. • In three of seven interviews with staff (43%), staff could describe the schedule for implementation of PNMP strategies. • In five of seven interviews with staff (71%), 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:	Noncompliance

#	Provision	Assessment of Status	Compliance
		• DCP on 512d was not able to describe why individuals used modified dining equipment. • DCP on 512b was not able to describe reasoning behind alternate positioning As with physical and nutritional Supports, the failure of staff to understand the consequences associated with not implementing interventions results in an overall environment where staff were 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 each individual; and the implementation by direct care staff of these interventions.	The Facility had not yet developed a system to monitor and address all the requirements of this provision, although progress had been made. Per maintenance spreadsheet and OT/PT monitors, a system still existed that was designed to routinely evaluate fit, availability, function, and condition of all adaptive equipment/assistive technology. A system did not exist that ensures staff responsible for positioning and transferring individuals at increased risk receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff (Refer to Provision O5). A revised monitoring process was being developed that focuses on a more comprehensive approach that addresses the effectiveness and use of OT/PT related equipment and interventions throughout the day. This process is in the trial phase, so a determination of effectiveness and adequacy cannot be determined at this time. Per POI, there is no formal process to ensure the selected 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 were now clearly documented from identification to resolution of any issues identified. This documentation was noted directly on the monitoring form. The issue with the process was that there was no data system to collect and aggregate data obtained from the completion of the monitoring forms.	Noncompliance

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

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, and medication administration. See Section O recommendations for additional information.
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. Note that fecal impaction or constipation is of course treated with medication but alternative positioning or lack of mobility and exercise can influence bowel functioning. Therefore, the individual may benefit from OT/PT input.

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 implemented 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 and formulating corrective strategies to address specific and/or systemic areas of deficiency.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. DSSLC Plan of Improvement (POI) 3/15/11 2. Settlement Agreement (SA) Presentation Book (undated) The following Facility policies and forms were reviewed: 3. Oral Hygiene, dated 2/17/2011 4. Oral Care for Enterally Fed Individuals, dated 2/17/2011 5. Policy for Dental Prophylaxis, dated 2/17/2011 6. Dental Clinic Operations, dated 9/13/2010 7. Dental Services Overview, dated 9/13/2010 8. Dental Examinations, dated 9/12/2010 9. Drug Interaction with Dental IV Sedation, no effective date for the policy 10. Annual Dental Summary Form, revised 2/8/2011 11. Dental Emergencies, statement, dated 09/13/2010 12. Records of the following individuals were reviewed: #292, #699, #524, #745, #141, #740, #616, #553, #49, #271, #656, #409, #494, #673, and #74 **People Interviewed:** 1. Dr. Cousins, DDS, Dental Director **2.** Pam Fournier, Dental Assistant **Meetings Attended/Observations:** Individuals at the Cedar Falls units were observed.
	Facility Self-Assessment: The Facility reports non-compliance with Provisions Q.1 and Q.2. The Facility reports that 98% of individuals had "routine annual examinations" and that all emergency dental care services identified have been completed. The Facility has hired an additional full time Dentist and has a position posted for a Dental Assistant. The Facility has developed a new Annual Dental Summary form, which better delineates dental needs. The Facility reports providing dental in-services to staff regarding oral hygiene and suction toothbrushing and that the Dental Director participates in the team process. A dental work group developed a cooperation classification index to assist the team with desensitization programs. The Monitoring Team recognizes many enhancements since the last compliance review; however, behavioral management, x-rays, treatments and participation in the team process remains deficient. For these reasons, the Monitor team concurs with the Facility's assessment of non-compliance with Provision Q.
	Summary of Monitor's Assessment: During this review of Dental Services, the Monitoring Team reviewed dental records, reviewed all current dental policies, observed individuals at Cedar Falls living area, and discussed dental services with the Dental Director, Dr. Cousins. The Monitoring Team recognizes efforts on the part of staff who helped to enhance dental services at the

	Facility. Since the last compliance review, the Facility had hired an additional full time Dentist, and had posted a position for a much needed additional Dental Assistant. The Facility had expanded the use of suction toothbrushes and instituted training for direct care staff of the importance of oral hygiene and preventative measures of aspiration pneumonia. A new "Annual Dental Summary" had been developed and implemented. This new form will better inform staff and the PST of oral health care and desensitization needs of the individual. The Facility had a clinically viable process to triage and provide emergency dental services. The Monitoring Team reviewed all dental emergencies subsequent to the previous review, noting 20 reported dental emergencies that were effectively managed. A potential rate limiting issue exists that may prevent further improvements in dental services. There was no effective means to maintain data specific to dental issues, nor to maintain a comprehensive, real-time, dental schedule. All data and scheduling were compiled manually, which resulted in system failures. The Facility was delinquent in providing dental services such as restorative treatments, and x-rays. This issue is reported to be secondary to not having necessary dental staff and to scheduling issues. The Facility must immediately implement enhanced measures to ensure that individuals are provided timely dental services, when clinically appropriate. Oral health care needs must be better incorporated into the PST process. The PST must fully understand the individual's oral health care issues; monitor progress review the use of sedation, restraint and desensitization programs; and ensure that services are provided promptly. Such issues and efforts must be well documented in the PSP. Despite recent improvements with providing oral care at the living area, this process must be immediately enhanced to ensure that all individuals at the Facility realize the benefits of quality oral care on a daily basis. Efforts to establish a meaningful desensitization program continue, albeit at a slow rate. A desensitization program must be fully implemented as soon as possible. Following review of Dental Services, the Monitoring Team recognizes the Facility's efforts. The Monitoring Team concurs with the Facility, and has determined that the Facility remains non-compliant with Provisions Q1 and Q2.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide	At the time of this compliance review, individuals requiring restorative dental services remained an issue for the Facility. A rate-limiting situation existed for individuals who require pre-treatment oral sedation. Because of limited staffing such individuals were not provided adequate dental treatment. As the result of the Facility hiring an additional	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	full time dentist, the Monitoring Team was informed that effective April 11, 2010, the additional dentist will be trained and providing services and all delinquent dental cases will begin receiving dental services. Because of significant issues with the ability to track dental procedures and maintain a "real-time" schedule, it was not possible for the Facility to provide the Monitoring Team with a timely accounting of the number of individuals who are currently delinquent with their restorative treatment – this would require a manual inspection of all of the dental records. During the Monitoring Team's discussion with Dr. Cousins regarding dental x-rays, Dr. Cousins informed the Monitoring Team that there were 152 individuals who were delinquent with dental x-rays; however, because the Facility had no mechanism to maintain real-time data on dental procedures, he was unable to provide a rationale for the delinquencies without reviewing each record independently. Subsequently, the Monitoring Team requested specific data regarding delinquent dental x-rays. Data provided to the Monitoring Team indicated 147 individuals delinquent with their required dental x-rays. More specifically, 31 individuals were delinquent secondary to appointment failures, seven because of scheduling oversight by staff, and 42 because of unspecified behavior issues. The remaining 67 were delinquent secondary to being edentulous, and in one case, not being able to physically cooperate with the exam. The Facility is determining a triage mechanism to ensure that when clinically appropriate, all individuals receive required dental x-rays. The Facility did have an effective emergency dental procedure in place. Per policy, all dental emergencies that occur during normal business hours are triaged through the dental office. After hours emergencies are initially triaged via the local emergency room with appropriate follow-up. The Monitoring Team reviewed data on dental emergencies subsequent to the review in October of 2010, and noted 20 dental emergencies documented in the dental records: Individuals #745, #141, #740, #616, #553, #49, #271, #656, #409, #494, #673, and #74. Following review of their dental records the Monitoring Team determined that all individuals were triaged timely and received follow-up assessment and treatments. Dr. Cousins informed the Monitoring Team that enhanced oral hygiene is being provided at certain living areas, but did not specify which living areas. During observation at Cedar Falls, the Monitoring Team noted that individuals had been provided routine oral hygiene at the living area. Dr. Cousins informed the Monitoring Team that he, along with the dental hygienist, had provided in-services to staff at one living area. There was no schedule, policy, procedure, competency based training records, or data to support the Facility's efforts on their enhancement of oral hygiene efforts. At the time of this review, only one living area, Cedar Falls, was provided specific training on suction toothbrushes.	

#	Provision	Assessment of Status	Compliance
		Specific to dental records and scheduling issues, Dr. Cousins, and Pam Fournier informed the Monitoring Team that the Facility relies on a single paper based schedule that frequently is inaccurate and does not provide real-time scheduling activities. Importantly, whenever the Dentist or Hygienist requires specific information about dental care, all of the dental records must be reviewed by staff. This inefficiency has led to failed appointments and treatments. There was no effective communication method between the living area and dental office. Following the Monitoring Team's review for Provision Q.1 of the Settlement Agreement, the Monitoring Team concurs with the Facility's assessment and determined that the Facility remains out of compliance with Provision Q.1.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	The Monitoring Team requested copies of all local policies related to dental services and was provided with the following: • Oral Hygiene, dated 2/17/2011 • Oral Care for Enterally Fed Individuals, dated 2/17/2011 • Policy for Dental Prophylaxis, dated 2/17/2011 • Dental Clinic Operations, dated 9/13/2010 • Dental Services Overview, dated 9/13/2010 • Dental Examinations, dated 9/12/2010 • Drug Interaction with Dental IV Sedation, no effective date for the policy • Annual Dental Summary Form, revised 2/8/2011 • Dental Emergencies, statement, dated 09/13/2010 Following review of the policies provided, the Monitoring Team noted that policies are vague and do not enable a comprehensive understanding of how dental practices are provided. Because there was no operational manual outlining procedures, policies should be more informative as to process. This is important so staff can better understand their roles and responsibilities. For example, the Facility had an excellent mechanism to triage dental emergencies; however, written statement for dental emergencies did not provide full insight into the process. For example, the statement did not comment on follow-up procedures following an emergency room assessment. Policy failures and poor implementation of policies had resulted in failure of adhering to the dental schedule, resulting in missed appointments and lapses in providing necessary dental services. Specific to "Dental Clinic Operations," the e-mailing of the schedule was not meeting expectation. Dr. Cousins reported to the Monitoring Team that despite the Dental Office sending out reminder emails of appointment times, countless individuals continue to	Noncompliance

#	Provision	Assessment of Status	Compliance
		miss their scheduled appointments. There was no policy and, or procedure per the Dentist or Hygienist outlining oral care responsibilities at the living area. The only policy provided specific to oral care was specific to oral care for enterally fed individuals, and in this case, the policy lacked specificity as to the type of oral suction device, how to use the device, and who should provide the service, as well as what should be documented. The Facility's attempt to improve participation in the PST process was ineffective. At the time of this review, the Facility had implemented a process that included a process, that when possible enabled the Dental Director to attend annual Personal Support Team meetings for persons with poor oral hygiene. So far, the Director has attended only three PSTs since January, 2011 (Individuals #292, #699, #524). Review of dental policies; review of PSPs of individuals #292, #699, #524, #745, #141, #740, #616, #553, #49, #271, #656, #409, #494, #673, and #74; and discussion with Dr. Cousins revealed that no further efforts had been made to enhance collaborative efforts with the PST process. A new dental form was created, "Annual Dental Summary", which does encapsulate quality information; however, the information was not being incorporated into the team process. It is essential that the PST is provided with meaningful information and data to ensure their full understanding of the individuals oral health care issues. The PST must make better efforts to understand oral health care issues and ensure that these issues are appropriately documented and ensure that appropriate services are provided timely. The Department of Psychology continued to develop a desensitization program for dental procedures. This issue, along with sedation is addressed in sections related to psychiatric and psychological services, respectively. It is important to note, however, that despite efforts by the Psychology Department, the Dental Office had not realized any benefit to persons served because of delays in development and implementation of programs. Also, because of development, and implementation delays of instituting a dental desensitization program, the Dental Hygienist had developed, independently, a specific desensitization program to assist in providing routine dental hygiene to individuals with challenging behaviors;. This program occurred weekly and iwas guided by the dental hygienist, who assisted people to gradually sit in the dental chair, followed by systematic exposure to dental equipment and procedures. The revised Annual Dental Summary now includes a "oral hygiene index scale, cooperation classification" to assist with analysis of desensitization. This new process may provide significant benefit in adjusting behavioral programs specific to the individuals needs.	

#	Provision	Assessment of Status	Compliance
		Following the Monitoring Teams review of Provision Q2, the Facility is determined not to be in compliance.	

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

1. Immediately develop and implement a system to provide real-time data to support dental services. Scheduling issues, procedures and treatments, x-rays, emergency dental services, behavioral issues, sedation, must be tracked effectively.

2. Immediately develop and implement a mechanism to ensure that all individuals who can benefit from dental services are provided necessary restorative and routine dental and oral care within a reasonable time period, when clinically appropriate.

3. Immediately ensure that suction toothbrushes and all other required oral hygiene measures are provided to all individuals at the Facility, when clinically appropriate.

4. Enhance communication between the PST, living area staff and dental office regarding necessary treatments and appointment schedules.

5. Immediately address the appointment failure rate at the Facility.

6. Dental office policies and procedures must be enhanced with regards to specificity. Given that there is no operational manual for staff to refer to, the policy is the only reference to provide guidance to staff.

7. Immediately develop and implement enhanced measures to integrate oral health care needs of persons served into the PST process and ensure that the PST gains full understanding of oral health care needs

8. The PST must immediately gain full understanding of oral health care needs and assertively monitor and advocate for prompt, efficacious treatments, including necessary dental x-rays, sedation issues, desensitization, restorative treatments, oral hygiene efforts at the living area, schedule dental hygiene, dental prosthetics and pathology specific to the individual.

9. Psychology and Dental services must immediately enhance collaborative efforts to initiate a desensitization program. The Dental Office's desensitization program must function in collaboration with that of the Department of Psychology's efforts and PST involvement.

The following are offered as additional suggestions to the facility:

1. Reach out to the Rio Grande Facility and determine if their scheduling procedure could benefit Denton.
2. Consider implementing a specific electronic dental record system or other electronic data base solution.

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:** **Documents Reviewed:** 1. DSSLC Plan of Improvement, (POI) 03/15/2011 2. Record reviews of Individuals: #114, #131, #171, #181, #201, #216, #218, #245, #272, #320, #336, #401, #419, #519, #537, #548, #578, #580, #696, #699, #758, #761, #776, and #781. 3. Policies, procedures and/or other documents addressing the provision of speech and/or communication services and supports (policy CMGMT-23- Communication Services) 4. Five Year Plan for Assistive Technology 5. Communication Therapy and Audiology Broken and Missing Report (3-28-11) 6. A list of people with Alternative and Augmentative Communication (AAC) devices 7. AAC evaluation and Speech Language assessment template. 8. Five (5) most current AAC and SLP assessments conducted by each therapist, and corresponding PSPs provided in response to the document request 9. Monitoring tools template for ACC and SLP programs. 10. Communication dictionaries for individuals identified as having decreased communication. 11. AAC-related spreadsheets. 12. List of individuals receiving direct speech services, and focus of intervention. **People Interviewed:** 1. Joy Sibley CCC-SLP Director of Communication Therapy 2. Donna Groves OTR Director of Habilitation Services 3. Life Skills Instructors (502) **4.** Four DCPs (Cedar Falls) **Meetings Attended/Observations:** 1. Life skills-Cedar Falls
	Facility Self-Assessment: For Provision R.1, the Facility stated they are not in compliance with this provision. DSSLC stated that a contract SLP started 10/2011 and that DSSLC continued to work with the agency to find additional SLPs. For Provision R.2, the Facility stated they are not in compliance with this provision. DSSLC stated that collaboration with the Behavior Support Committee continues and that assessments continue to be completed. A total of 211 had been completed since April 2008. For Provision R.3, the Facility stated they are not in compliance with this provision. DSSLC stated that all individual devices are portable and functional and that all general area devices benefit individuals to participate more fully in activities. Total devices for DSSLC were as follows: • 273 shared AAC devices • 74 individual AAC devices • 46 shared environmental control (EC) devices

	• 41 individual EC devices For Provision R.4, the Facility stated they are not in compliance with this provision. DSSLC stated that a final contract amendment was sent to University of North Texas to expand the number of graduate assistants by seven in an effort to have more skilled monitoring and training. The self-assessment of noncompliance in all sections was consistent with the monitoring team's assessment of noncompliance with this provision.
	Summary of Monitor's Assessment: **Provision R.1:** This provision was determined to be not in compliance. DSSLC only has 2.5 SLPs on campus. 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. Plans are not implemented secondary to excessive delays in the acquisition of devices or devices being broken or missing. **Provision R.4:** This provision was determined to be not in compliance. DSSLC had a monitoring form that tracked the presence and working condition of the AAC equipment; however, implementation was not consistent due to lack of available staff. Due to the lack of staff availability, progress in these areas continues to show very slow improvement. Effort focusing on the use of object cards and integration of these cards into life skills training continues on the Cedar Fall's apartment 502. Improvement was noted with life skills training but no improvement was noted at the apartments.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience	The Facility did not provide an adequate number of speech language pathologists or other professionals (such as Assistive Technology [AT] specialists) with specialized training or experience so that individuals with identified Speech issues receive the necessary services. There were only 2.5 speech therapists available at DSSLC. In addition to the licensed therapists, DSSLC had three graduate assistants, and three stipend students. Two of three stipend students were scheduled to become full time in September 2011.	Noncompliance

#	Provision	Assessment of Status	Compliance
	demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	DSSLC has also revised their contract to include an additional seven graduate students but this had not been filled at this time. With the current numbers, it will be extremely difficult for DSSLC to begin to address the issues identified in this section. Average caseload with the current staffing is approximately 250 individuals per clinician. Individuals with identified language difficulties were not receiving active Speech Treatment or participating in a Speech program. This was determined by reviewing the Five Year Plan, which identified individuals who were determined to have moderate to severe speech/language deficits. As of this review less than 50% had received a speech or language assessment. Per interview with the Director of Communication Therapy, SLPs still do not participate in the PSPs for individuals with severe or moderate speech deficits outside of Cedar Falls. Again, this is a direct result of not having enough therapists. Communicative aids and speech-generated devices (simple and complex) were 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. (i.e., PSPs, PNMT meetings).	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	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. For example, Individual #245's PSP merely stated 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. There were numerous other examples that can be found among the individuals for whom documents were reviewed (listed in Documents Reviewed above). The majority of the individuals living at DSSLC have not been provided with comprehensive Speech or AAC assessments. Per interview with the Director of Communication Therapy, DSSLC has developed a 5 year plan; however, per the Director of Communication Therapy, it was not expected that the individuals identified in the priority list as moderate and severe would receive services meeting their needs within that timeframe unless the Facility's efforts to hire and retain staff are effective. Additionally, the communication master plan only outlines the initial completion of the comprehensive assessment and not the future schedule of assessments. Additionally,	Noncompliance

#	Provision	Assessment of Status	Compliance
		many individuals identified by DSSLC as having severe language deficits were not scheduled to be provided with comprehensive assessments that fully investigate AAC until as late as 2014. While a process exists, it was not effective in identifying individuals in need as assessments were not completed in a timely manner and when assessments were completed, acquisition of needed equipment was significantly delayed. Per interview with the Director of Habilitation Services 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. Upon review of assessments completed within the past few months, the new assessments are much more comprehensive and appear to address the concerns listed below, but they have not been consistently implemented or implemented in a sufficient quantity as to demonstrate that these improvements will be evident in all assessments and allow compliance to be determined. In five of the 24 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. For persons receiving behavioral supports or interventions, the Facility has a process designed to identify who would benefit from AAC or speech assistance. The SLP had begun to attend all Positive Behavior Support Committee meetings and provide consultation to the applicable psychologists regarding speech or language issues that may be contributing to the target behavior. While DSSLC has a communication policy, the frequency of assessments were not clear as it simply referenced the communication master plan and did not contain information and assessment schedule.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three	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	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	consistently integrated into Action Plans or activities of daily living. Lack of integration results in decreased opportunities for the communication strategies to be used during all daily activities and for learning to take place. Five of the 24 records reviewed (21%) had a clear rationale and description of communication interventions integrated into the PSP. Examples of PSPs in which communication was not adequately integrated: • Individual # 419's PSP stated that the individual is nonverbal but did not provide information on how to expand or integrate strategies into the daily schedule. • Individual #245's PSP merely stated 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 24 records reviewed (21%) clearly indicated how the individual communication programs were functional and meaningful to the individual and how it improved his/her daily living. Examples of how the goals will help improve overall quality of life and how the goal is related to improved speech should be clearly documented in the assessment as well as the Training Directive. DCPs were not knowledgeable of the communication programs as evidenced by: • In two of four interviews (50%), DCPs were not able to locate adaptive equipment. DCPs not being able to locate equipment results in lack of training of equipment. • In one of four interviews (25%) with staff, staff could describe individual-specific communication strategies. • In four of four interviews with staff (100%), staff could not describe the schedule for implementation of communication strategies. • In two of four interviews with staff (50%), 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 four DCPs at Cedar falls indicated that staff were not knowledgeable of the communication dictionary or its contents. • A Life Skills Instructor could not describe the link between environmental control devices and AAC.	

#	Provision	Assessment of Status	Compliance
		General AAC devices were not readily available in all common areas; however, this is an area that has continued to show improvement. As of this review there were a reported 273 shared AAC devices at the apartments. While the number of devices had increased, the use of the devices throughout the day had not increased unless a formal goal was being trained. During the observations on Houston Park and Cedar Falls, limited to no use of the shared devices was observed. Many individuals who had been provided with assessments by the SLP and recommended for AAC had not received the needed devices. Per interview with the Director of Communication Therapy, this is often due to ordering issues and delays. Recommendations for AAC and EC equipment were not implemented in a timely manner. For example; • Individuals #645, #691, #571's devices were ordered in February, 2010 but the devices still have not arrived. • Individuals #114, #171, and #696 did not have Training Documentation Reports (TDRs) implemented as stated by the assessment. The issue with equipment delays was a pervasive issue and is an unacceptable practice. In addition to the delays, there was not a clear process in place to assist the individual in communicating while the device is ordered. Per interview with the Director of Communication Therapy, there should be individualized communication dictionaries available in the "Me" books (the Individual Notebooks); however, as mentioned earlier, staff were not knowledgeable of these dictionaries.	
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	DSSLC had a monitoring form that tracked the presence and working condition of the AAC equipment; however, implementation was not consistent due to lack of available staff. 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 Director of Communication Therapy, 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. An equipment checklist was implemented but as stated	Noncompliance

#	Provision	Assessment of Status	Compliance
	communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	above, the frequency of the monitoring was informal and not consistent due to staff availability. In addition to equipment being delayed, equipment was also often missing and not available to the individual. Per review of the Communication Therapy Equipment Missing/Broken List dated 3-28-11. 37 devices were either missing or broken. Some devices had been missing since 2/10/10. Validation checks were not built into the monitoring process and conducted by the plan's author to ensure correct implementation or inter-rater reliability between monitors.	

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

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. 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.
3. 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.
4. 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.
5. Develop a process that ensures needed AAC and environmental control equipment is ordered and received in a timely manner.
6. Individuals who have been identified as being in need of AAC should have alternate devices available while personal devices are on order or being repaired.

The following are offered as additional suggestions to the facility:

1. DSSLC may want to consider having the night shift complete the equipment checklist on a daily basis to ensure equipment is present and readily available for use.

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 State Supported Living Center (DSSLC) Plan of Improvement (POI), 03/25/2011 2. Facility Policies and Procedures 3. Minutes for the Behavior Services Peer Review Committee meetings and departmental meetings. 4. Preliminary materials for Competency-Based Training. 5. Documents that were reviewed included the annual PSP, PSP updates, Special Program Objectives (SPOs), Positive Behavior Support Plans (PBSPs), structural and functional assessments (SFAs), 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, task analyses, and behavioral and functional assessments. All documents were reviewed in the context of the POI and included the following individuals: #19, #79, #107, #108, #110, #119, #123, #127, #134, #183, #208, #226, #229, #232, #238, #240, #250, #255, #297, #306, #319, #337, #367, #381, #399, #413, #460, #483, #494, #506, #537, #539, #540, #557, #565, #609, #624, #629, #664, #669, #687, #753, #772, and #774 **People Interviewed:** 1. Randy Spence, MS – Director of Behavior Services 2. Rick Smith, PhD, BCBA-D – Behavior Services consultant 3. Jill Wooten, MS, BCBA – Psychologist 4. Katy Acheson, MS, BCBA – Contract Psychologist 5. Bryan Lovelace, MS, BCBA – Psychologist 6. Leigh Rogers – Psychology Assistant 7. Frank Padia – Director of Program Coordination 8. Shillonda Perkins – QMRP Coordinator 9. Leslie Clark – QMRP 10. Kizzy Mickels – QMRP 11. Julie Kuester – QMRP 12. Linda Ford – Director of Active Treatment 13. Ken Horstman – Director of Residential Services 14. Ynez Coleman, RN 15. One program staff in Employment Training Center (ETC) 16. Carmen Stearns 17. John Russell – Wellness Program instructor 18. Approximately 20 direct care staff **Meeting Attended/Observations:** 1. PSP for Individual #413 (3/29/2011) 2. Restraint Reduction Committee (3/30/2011)

	3. Section K Committee Meeting (3/30/2011) 4. Conducted observations in Residence 504, 505, 508, 522, 523, 524, 525, 526, 527, and 528 (3/28/2011 – 3/31/2011) 5. Conducted observations in the Employment Training Center, Gymnasium, ICD, and Job Training Center (3/28/2011 – 3/30/2011)
	Facility Self-Assessment: The Facility indicated in the Self-Assessment and POI that substantial compliance had been achieved in none of the provisions of Section S. The Monitoring Team agreed with the facility assessment. It was disconcerting to encounter continued lack of compliance with the SA in regard to Section S. Of even greater concern, however, was the loss of progress previously achieved in areas such as the number of opportunities provided for community activity. In addition, the Facility included in the Self-Assessment statements that could not be supported by observations or interviews conducted by the Monitoring Team. • DSSLC indicated that, as of 1/1/2011, "Assessments to address all areas of a person's life are identified at 3rd Qtr PSP meeting. In addition, assessments are developed using preferences identified at 3rd Qtr PSP Meeting using Personal Focus Assessment tool. " It was determined by the Monitoring Team, however, that the PFA was seldom completed as intended, and that the completion of the PFA was often consigned to a secondary role. • DSSLC indicated that, as of 1/1/2011, "Assessments are completed and reviewed by PST members prior to annual PSP meetings." Reviews by the Monitoring Team, however, indicated that assessments are at best completed and submitted inconsistently. Furthermore, the lack of consistent and complete assessments was reported by staff to be a chronic problem that had received minimal correction during recent years. It is crucial that DSSLC recognize not only the importance of achieving compliance with the SA, but also the essential need for accurate and complete self-assessment. The inability to recognize either the lack of progress or the loss of previously achieved progress will undoubtedly hamper the compliance process. It must be noted that the Facility Self-Assessment and POI, although helpful to the Facility, are only limited tools to be used as guides. The Monitoring Team, in offering comments in response to the Self-Assessment, is attempting only to add focus to the efforts by the Facility and assist the Facility in making essential changes. A Self-Assessment that accurately rates all elements as being in substantial compliance is not sufficient for determining that the Facility has satisfied all elements of the Settlement Agreement.
	Summary of Monitor's Assessment: Based upon observations, record reviews and interviews with employees, the Monitoring Team identified a considerable lack of progress by DSSLC in achieving compliance with Section S. Weaknesses noted in previous site visits continued unabated and changes reported as progress were, at best, substantial overestimates of achievement. The current determination by the Monitoring Team was that minimal change had occurred in relation to Section S requirements in comparison with the baseline visit in the First Quarter of 2010.

	For Provision S.1: This provision was determined to be not in compliance. Skill acquisition programs continued to lack essential components and formal teaching was encountered only sporadically. **For Provision S.2**: This provision was determined to be not in compliance. The PFA was seldom completed as intended and assessments required for the PSP were frequently not submitted to the appropriate location or not submitted at all. **For Provision S.3:** This provision was determined to be not in compliance. Community outings reflected a declining trend over several months and staff reported that skill acquisition programs are not typically implemented in the community.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>S1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.</td><td>The review process consisted of a review of the records for 25 individuals, as well as observations of program implementation. These were records for Individuals #19, #79, #107, #110, #229, #232, #238, #240, #250, #255, #297, #306, #319, #460, #483, #494, #537, #540, #557, #609, #629, #664, #669, #753, and #772.

Due to the goal of strengthening a skill or behavior, effective skill acquisition 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 weak to non-existent assessment of client abilities, as well 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, the approach to training, education, and skill acquisition at DSSLC had changed minimally since the baseline visit. In relation to assessment, the following conditions were noted.

<table>
<tr><td>Area</td><td>9/2010</td><td>3/2011</td><td>Change</td></tr>
<tr><td>Psychological assessments included a formal</td><td>0%</td><td>17%</td><td>17%</td></tr>
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</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance

assessment of intellectual ability completed within five years of the report			
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	0%	0%	0%
Records reviewed reflected the use of a formal task analysis or preference assessment	0%	0%	0%

Of particular concern in regard to assessment was 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. Nevertheless, 100% of all skills acquisition programs were based upon the PALS.

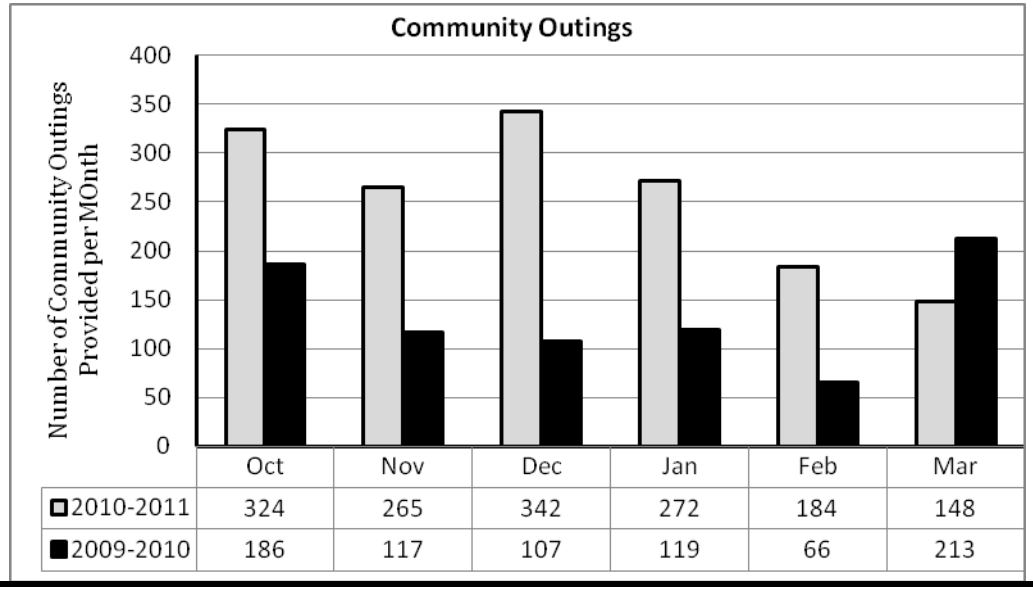
Substantial limitations were also encountered in the components of skill acquisition plans. In 25 of 25 records reviewed (100%), target behaviors or skills lacked operational definitions, teaching procedures lacked sufficient specificity to ensure consistent implementation, training sessions were too 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.

Area	9/2010	3/2011	Change
Plan reflects development based upon a task analysis.	0%	0%	0%
Behavioral objective(s).	0%	0%	0%
Operational definitions of target behavior.	0%	0%	0%
Description of teaching conditions.	0%	0%	0%
Schedule of implementation comprised of sufficient trials for learning to occur.	0%	0%	0%
Relevant discriminative stimuli.	0%	0%	0%
Specific instructions.	0%	0%	0%
Opportunity for the target behavior to occur.	0%	0%	0%
Specific consequences for correct response.	100%	100%	0%
Specific consequences for incorrect response.	0%	0%	0%
Plan for maintenance and generalization that includes assessment and measurement methodology.	0%	0%	0%

#	Provision	Assessment of Status	Compliance
		Specific examples of limitations found in skill acquisition programs are presented below. • For Individual #232, the implementation instructions were, "Staff will explain to the Individual that it is time to begin an activity. Provide the Individual a choice of at least two activities. After the Individual chooses one, set it up for her (gather all supplies and place them within reach). Provide a demonstration of the activity if the Individual is unfamiliar with it, explaining the steps as you go. After demonstrating, provide a verbal prompt to begin the activity. Tell the Individual you are going to count aloud to 60 and you would like for her to begin before you stop counting. Record a"+" if the Individual begins the activity within 60 seconds and a"-" if the Individual does not. Verbal praise was used as a reinforcer. Continue to assist with the activity as needed." As written, the teaching methodology introduced several problems. o There was no indication that the presented activities were to be activities the Individual typically preferred. o There were no criteria for determining whether the choice made by the Individual was an actual indication of preference as opposed to a random selection or a behavior that was reinforced by escape from demands or social reinforcement. o There was no indication that the reinforcer for success (verbal praise) was more powerful than reinforcement achieved by escaping from an undesired activity by having declined to participate. o Depending on what stimuli are reinforcers for the individual (for example, attention from staff versus escape from demands), the procedures could be counterproductive. For example, if escape is a reinforcer, the individual might learn to wait till the end of the counting and then not engage in the activity, and counting might be come a cue that escape can occur simply by sitting quietly. If attention is a reinforcer, the individual might also wait till counting is over, because starting earlier would mean attention would end. o The instruction to "Continue to assist" provides little guidance. If, at the end of counting to 60, the individual does not participate and the staff continue to prompt, the counting is likely to lose effect as a discriminative stimulus for reinforcement. Continuing to assist if the individual does not participate may provide significantly more attention than would intermittent praise; if attention is a reinforcer, this might be ineffective in increasing participation and might inadvertently reinforce and increase problematic behaviors that lead to getting assistance. • For Individual #664, a skill acquisition program with the goal of teaching money management skills involved guiding the individual through the process of making a choice. Not making a choice was to be recorded as an unsuccessful training session. There was no indication that the act of choosing was related to	

#	Provision	Assessment of Status	Compliance
		money management or was a skill deficit. • A skill acquisition program for Individual #557 included the goal to improve communication skills. The objective of the program was to teach the Individual to understand the importance of wearing a hearing aid. There was no indication of how this objective would increase communication skills or the frequency with which the hearing aids were used, as the Individual was unable to independently apply the hearing aids. In addition, although the Individual required hearing aids, there were no instructions in the program to ensure the Individual was wearing hearing aids during training. • For all skill acquisition programs reviewed, there was no specific response to be offered for an unsuccessful trial. • For all skill acquisition programs reviewed, there was only a single training session implemented per day. Teaching new behaviors requires high rates of reinforcement to be successful. Observations were conducted in residences 504, 505, 508, 522, 523, 524, 525, 526, 527, and 528, as well as the Employment Training Center, Gymnasium, ICD, and Job Training Center to assess the quality of skill training. Only in two settings (14%) were individualized and effective teaching skills demonstrated. • In ETC Room 1, staff were observed to used high rates of specific reinforcement for successful trials. In addition, an opportunity developed for one Individual to use appropriate escape had substantially increased work performance. • In the Gymnasium, staff were observed to use prompting, shaping and modeling with a high rate of success in gaining cooperation for exercise.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	Record reviews revealed that for 25 of 25 individuals, documentation of annual 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, and preferences 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. Although difficult to quantify by observation, various staff, such as QMRPs, psychologists, nurses and DCPs expressed concerns about the PSP and assessment process. If accurate, these concerns, which are listed below, reflected substantial limitations in the PSP and assessment process. If inaccurate, these concerns could be indicative of problems in staff	Noncompliance

#	Provision	Assessment of Status	Compliance
		cohesion, training and supervision. • The QMRPs reported that the PFA was seldom completed as intended. In addition, the QMRPs perceived the PFA to be poorly designed, lacking utility, and overly difficult to complete. QMRPs and other PST members at times praised the intent of the PFA process, but expressed frustration with how poorly the PFA instrument satisfied the intent. • The PFA meeting was integrated into the Psychiatric Review meeting, but reportedly not allotted adequate time. For example, it was reported by QMRPs that the PFA meeting was often prematurely terminated or not conducted at all due to a lack of time. Please refer to Provision F.1.d for data on timeliness of PFA completion and documentation. • QMRPs reported that assessments were frequently not submitted to the appropriate location on the server or not submitted at all prior to the PSP. When submitted, it was reported by the QMRPs that assessments were often duplications of or highly similar to assessments from previous years. These were indicated as chronic problems that have existed for at least two years. • A lack of consistency across departments was reported by QMRPs for complying with PFAs and skill assessment timeframes and content.	
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.	Noncompliance
	(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. For 25 of 25 Individuals (100%), training programs lacked structure, being presented without clear steps or trials. b. For 25 of 25 Individuals (100%), consequences that were intended as reinforcement following successful attempts during training involved verbal praise. Verbal praise can serve as a reinforcer, 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		c. For 25 of 25 Individuals (100%), 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. a. For Individual #232, a skill acquisition program included specific instructions for prompting participation ("Tell the Individual you are going to count aloud to 60 and you would like for her to begin before you stop counting"). Instructions for additional prompts, however, were much more vague ("Continue to assist with the activity as needed.") d. For 25 of 25 Individuals (100%), data for skill acquisition programs were not graphed, nor were summaries of progress adequate to determine whether interventions were effective in addressing the individual's needs. e. In addition to lack of graphed data, it was also not clear from available progress notes that individuals had strengthened existing behaviors or developed new skills because of skill acquisition programs.	
	(b) Include to the degree practicable training opportunities in community settings.	At the time of the site visit, DSSLC had generally increased the total number of community activities compared with the same time frame from the previous year. A trend analysis, however, reflected a steady decline in the number of community activities in the First Quarter of 2011. This decline culminated in March where 65 fewer outings occurred than did in March of 2010. It was evident that progress previously achieved in increasing community opportunities had stopped or reversed.  |	Oct	Nov	Dec	Jan	Feb	Mar
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2010-2011	324	265	342	272	184	148
2009-2010	186	117	107	119	66	213		Noncompliance

#	Provision	Assessment of Status	Compliance
		Some progress was demonstrated in community employment for individuals living at DSSLC. During the previous site visit, five individuals were employed in the community. During the current site visit, it was noted that there were now six individuals with community jobs. 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 one employment position 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. These training attempts, however, were informal and did not reflect an extension of skill acquisition programs included in the PSP. 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. Furthermore, training was presented on campus when training in the community would be most relevant for the skill to be learned. For example, as described in the finding for Provision T.1.b(1): • For Individual #295, the PST found that the individual's overall vision was to get a higher paying job in the community, and also noted that he appeared to be interested in community activities. The team acknowledged that he had not been exposed to any other living options, but stated further they were concerned for the individual's safety if he lived in the community because he is independent and likes to walk about the neighborhood, but has few pedestrian skills. The team determined the most integrated setting for this individual was DSSLC, despite his preferences for community integration, and did not develop any strategies for exposing him to learning opportunities about living options, nor community employment. The only strategy developed for the obstacle of pedestrian safety was a training program that consisted of prompting him to stop at the crosswalk when going to evening activities on campus, rather than training that would allow him to learn pedestrian safety in a community setting.	

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

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 analysis and 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 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), updated 03/15/2011 2. DSSLC's Report for Monitors, dated March 28, 2011 3. DSSLC Policy on Personal Support Planning Process, Policy Number CMGT-12.01, dated 1/03/11 4. DSSLC Policy on Most Integrated Setting Practices, Policy Number CMGMT-39, dated 10/30/09 5. Draft DADS Policy 018: Most Integrated Setting Practices, dated variously 1/27/10 and 0/00/11 6. Since October 1, 2010, a list of three individuals who have been referred for community placement by his or her PST. 7. Since October 1, 2010, a list of all individuals who have requested community placement, but have not been referred for placement. 8. Since October 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." 9. Since October 1, 2010, a list of individuals who have been discharged pursuant to an alternative discharge. 10. A current list of all alleged offenders committed to the facility following court-ordered evaluations. 11. A list of 566 individuals who have been assessed for placement for the period between 3/10/10 and 2/28/11, date of assessment, and resulting recommendation(s) 12. Community Placement Report, dated March 01, 2011 13. 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 14. Since October 1, 2010, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed 15. Mental Retardation Authority (MRA) Community Living Options Information Process (CLOIP) Worksheets for 39 individuals with PSPs held in March 2011 16. Personal Support Plans (PSPs) for ten Individuals #68, #197, #295, #432, #458, #579, #606, #621, #645, and #687 17. Personal Focus Assessments (PFA) for 28 Individuals #37, #68, #121, #149, #197, #216, #222, #239, #270, #293, #295, #317, #362, #383, #385, #395, #413, #432, #458, #530, #545, #579, #606, #645, #687, #691, and #730 18. Revised Community Living Discharge Plan instructions and format, undated 19. Completed CLDPs for four Individuals #406, #685, #777, and #795 20. Partial CLDPs for three Individuals #232, #237, and #384 21. CLDP Attendance Signature Sheets for four Individuals #406, #685, #777, and #795 22. Pre-Move Site Review document for Individual #178, dated 3/29/11 23. MRA Continuity of Care Pre-Move Site Review Instruments for three Individuals #406. #795, and #777

	24. Community Placement Report for the period 9/1/2010-3/1/2011, dated March 01, 2011 25. DSSLC report entitled Obstacles to Movement, undated 26. DADS Obstacles Report for the State Supported Living Centers, dated 10/10 27. Completed Post Move Monitoring (PMM) checklists for four Individuals #406, #685, #777, and #795 28. Section T Settlement Agreement Cross-Referenced with IC-MR Standards, Revised February 2011 **Persons 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. Jody Vicars-Nance, Admissions and Placement Coordinator (APC) 6. Stephanie Laury,QMRP 7. Debbie Burgett and Diane Thomas, Admissions and Placement APC Specialists **Meetings Attended/Observations:** 1. PSPs for two Individuals #691 and #293 2. Pre-Move Site Visit for Individual #178 3. Personal Focus Assessment (PFA) meetings for Individual #557 and #572 4. CLDP Meeting for Individual #618
	Facility Self-Assessment: The Monitoring Team reviewed the DSSLC POI. Overall, the Facility indicated it was not in full compliance with any of the provisions of Section T. **For Provision T1**, the Facility indicated that it believed it was not in compliance with most of the sub-sections, with the exception of the requirement to review the CLDP with individuals and with LARs/family members as appropriate, and the issuance of the Community Placement Report. The Monitoring Team concurred with these assessments of compliance and non-compliance, with the exception of the issuance of the Community Placement Report. Reported compliance with this requirement was not substantiated. The POI also noted a number of actions the Facility had taken since the previous site visit, including the development of new policies and processes related to the Personal Support Plan, the development of a PSP Workgroup tasked to assess and assist Personal Support Teams (PST) in facilitating annual meetings, and the recent implementation of the revised CLDP process and format. The Facility also reported it had recently received revised monitoring tools for this Section, although they had not yet been implemented. The Monitoring Team reviewed these materials and felt it was important to provide a note of caution, in that some of the guidelines provided for those who will use the tool did not appear to be consistent with the Settlement Agreement (SA) requirements. For example, the guidelines for Subsection 2, number 4, related to Post-Move Monitoring, suggests the Post-Move Monitor may only be responsible for follow-up on deficiencies that appear to be essential to health and safety if those are also deficiencies for which the Facility is accountable. The Monitoring Team does not concur with this interpretation. The Facility must have documentation of having used its best efforts to ensure implementation if it identifies *any* deficiency in the provision of *any* support, as stated in the SA. In Subsection 1, number 1a, related to identifying the most integrated setting, the guideline indicates there should be documentation that the PST members were

	individually in consensus with the placement decision. Certainly each professional member of the team has a responsibility to consider each individual's most integrated setting in his or her assessment; however, the consensus of the team as a whole as to the most integrated setting appropriate to an individual's needs would not be negated if one member disagreed. The State and the Facility should review these guidelines as a whole to ensure they are consistent with the requirements of the SA, the ADA and the Olmstead decision. The Monitoring Team appreciates the State's and Facility's efforts to use self-monitoring tools and to revise the self-monitoring tools that were based in part on the original monitoring team checklist tools; at this point, all of the state's monitoring tools probably need a review for content. **For Provision T2**, the Facility stated it was not in compliance with the PMM process. Actions reported in the POI include a weekly review of monitoring visits by the Director of CFR and the reporting of all PMM deficiencies to the sending PST. **For Provision T3**, no rating was required. **For Provision T4**, the Facility indicated it believed this provision was not applicable, although it reported a draft policy and procedure related to this provision was under revision.
	Summary of Monitor's Assessment: DSSLC indicated that it was not in compliance with any of the provisions of this Section, but did report it had achieved some level of compliance in two component areas, those being in the CLDP process and the Community Placemen Report under Provision T1. 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. In most instances this was consistent with the Facility's self-assessment. The Facility continues 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. In the POI, the Facility stated it was developing a proposal for a more comprehensive and cohesive educational plan, but this was not yet available for review. It had done little during this monitoring period to provide education and promote awareness of community living options, providing documentation of only eleven individuals and 18 staff participating in community tours for a four month period. On the other hand, the Monitoring Team was pleased to see a significant degree of involvement of Contract MRA staff in one PSP meeting during this site visit. There was good interactive discussion between the PST members and the MRA staff, with the former requesting information about community providers, processes, supports and services, and the latter serving an important technical assistance and educational role. The Facility did report it believed it was in compliance with one indicator related to the participation of the individual and LAR in the CLDP. The Monitoring Team found there had been progress in defining the

	process, organization and structure of the CLDP meeting, but the Facility had only recently begun to implement the modified and expanded CLDP process. This included the requirements for documenting participation of individuals and LARs, but there was not yet a single completed example of the new CLDP available to review. The Monitoring Team looks forward to viewing samples of fully completed CLDPs at the next sit visit. The Facility also reported it was in compliance with component T1h, the issuance of the Community Placement Report at required six month intervals. The Monitoring Team concurred. However, the Monitoring Team found that PSTs were not always accurately reflecting in their deliberations that the finding of the Facility as the most integrated setting was driven by the preference of the LAR. While the Community Placement Report indicated that there were no individuals included in that category, the Facility reported elsewhere in the document request that there were individuals who had requested community living, but were not referred due to LAR choice. **Provision T2:** This provision was determined to be not yet in compliance. Overall, the Facility had made significant progress since the last site visit, although it did not yet rise to the level of substantial compliance. The Monitoring Team found that the PMM Checklists were being completed in a timely manner. Although the PMM Checklists reviewed were being completed in a timely manner, the process used to complete them was not yet thorough or adequate to be able to state with certainty that the essential and non-essential supports were actually in place. That said, the Post-Move Monitor had made substantial improvement in the documentation of follow-up for identified deficiencies in the provision of supports, and was to be commended for thoroughness and attention to detail. The potential for PMM visits to be missed when the process took place across catchment areas was an area of concern during the site visit in 7/10, but this appeared to have been resolved through a tracking system devised and maintained through DADS state office. In addition, the Facility reported it would only be monitoring individuals placed from DSSLC in the future. **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 not rated as no alternative discharges were reported. 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 it is recommended the Facility have policies and procedures in place to define its processes. The draft DADS Policy 018: Most Integrated Setting Practices addresses the requirements for alternate discharges and provides a template for discharge summaries for these individuals in Exhibit F. Once formally promulgated, this policy should be sufficient to provide guidance for the development of the Facility-level policy and procedure.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**	This Provision was found to be not in compliance.	Noncompliance
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.	DSSLC had made few placements and even fewer referrals in the past six months. There were only five individuals who transitioned to community living and only three referrals made by PSTs. As was the case during the last site visit, less than 1% of the population transitioned to the community in the past six months, a pace well below that of most other SSLCs. DSSLC had undertaken some 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. • DSSLC had continued implementing the new statewide PSP process. According to the Report to Monitors provided at the entrance meeting, 1739 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 approved the hiring of two additional part-time CFR staff to assist with community transition planning and awareness. • The Facility had also begun monitoring the PSP process, using the PSP Checklist. See Provision F2g for additional detail. These are positive steps, but these initiatives had not been implemented long enough to be able to adequately assess their eventual impacts on compliance with the overall requirements of this component. As detailed in the rest of this Section T and in Section F above, outcomes in the areas of assessment and planning for protections, services and supports; education for community awareness; transition and discharge planning; and, post-move monitoring indicated the Facility could not be said to be effectively assisting and encouraging individuals to move to the most integrated setting yet. There were a number of instances in which the Facility and its PSTs failed to proactively encourage individuals to the most integrated setting, including the following examples: • During the last site visit, on 9/29/10, the Monitoring Team observed a PSP for Individual #562, in which the LAR expressed opposition to community placement. Following the meeting, in light of the individual's stated preferences for community living, the LAR stated she would be willing to reconsider. The Monitoring Team noted in its report that the LAR 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 the individual 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 the individual had to fit into the available placements, not that a	Noncompliance

#	Provision	Assessment of Status	Compliance
		community placement could be designed to meet his needs. During this visit, the Monitoring Team reviewed the completed PSP from 9/10. It indicated the LAR was open to allowing the individual to tour community homes as long as she was also able to attend. The PSP further stated the team would arrange for future tours. No action plans were developed to achieve this objective, and a review of the record indicated that no community tours had been planned or completed in the past six months, and no follow-up communication had been documented with the LAR to provide further assistance in this area. • At the annual PSP planning meeting for Individual #691, the need for a specialized "bathing table" was stated to be an obstacle for movement to a more integrated setting. The Monitoring Team observed the bathing table, which was actually a flat bathing slab. Not only should this not have been considered an obstacle to movement, it also is not a safe, comfortable, and dignified way to bathe individuals living at the Facility. The Facility should replace bathing slabs with tubs adapted to meet the needs of individuals served.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	This component was found to be not in compliance. The Facility had developed a new Personal Support Plan Process policy related to transition and discharge processes. This was generally consistent with state-level most integrated setting policies. The Facility also provided the Monitoring Team with a copy of a draft of DADS Policy 018: Most Integrated Setting Practices, dated variously 1/27/10 and 0/00/11. This policy provided several updates to the previous version. These updates had not yet been incorporated into local policies and procedures, although the Facility was in the process of implementing a number of the changes.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent	The PSTs at DSSLC continued to need additional training and mentoring in the identification of protections, supports and services individuals will need in the most integrated setting, as well as in the identification of obstacles to movement to the most integrated setting. This is consistent with a need to improve their overall abilities to function as effective interdisciplinary teams in the assessment of individual needs and the supports and services needed at DSSLC, and in their understanding of their responsibility to complete a professional assessment of an individual's most integrated setting appropriate to his or her needs and preferences and to identify the obstacles to movement to that setting. This is described in more detail under Provision F1e above. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	Personal Focus Assessment (PFA), completed by the individual, family and PST during the third quarter preceding the annual PSP. As described in section F1b, F1c and F1d above, the PFA process was not currently implemented in a manner that was particularly meaningful to the individual nor likely to elicit information about the vision for the individual's future. For many individuals, the PFA meeting was being held as a part of the third quarter Psychiatric Medication Review, a process that was not consistent with the PFA objective of focusing on personal goals, preferences and strengths. For one of two PFA meetings (50%), a family member participated in person. This participation is an essential component of the PFA process. The rote questioning process by which the PFA was implemented for one meeting was also unlikely to support adequate participation by an individual; for the other meeting, the issue of preferences was one of many topics (with the initial focus being on the psychotropic and antiseizure medications). Even during discussion of preferences, the focus was on preferred activities, with no discussion of a vision for future living. The Monitoring Team reiterates its recommendation that 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. The Monitoring Team recommends that the Facility implement a formal curriculum for "planning my future" that is incorporated into the overall active treatment program on an ongoing and regular basis. Information regarding person-centered training models that might assist QMRPs to better facilitate this process may be found at: http://www.ilr.cornell.edu/edi/pcp/courses.html. The Monitoring Team attended two PSP annual planning meetings and reviewed 10 PSPs completed using the new process and format for the purpose of evaluating this component. Consistent with the findings under Provision F, the PSTs did not exhibit proficiency in the assessment of the most integrated setting appropriate to an individual's needs, the identification of needed supports and services in that setting other than those things being provided at the Facility, or the obstacles and/or strategies to overcome those obstacles. Examples included: • As described in T1a above, the PST did not implement strategies to overcome barriers to the most integrated setting for Individual #562. Even though the team had identified the need to arrange group home tours for the individual and LAR, no action plan was created and no tours were offered. • For Individual #645, the PST identified that the individual's lack of knowledge of available community living options would prevent her from making an informed decision, but also noted he LAR did not want the individual to make group home tours. The only strategy the team devised to address this obstacle was for the individual and LAR to be contacted annually by the Contract MRA. • For Individual #295, the PST found that the individual's overall vision was to get a higher paying job in the community, and also noted that he appeared to be	

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		interested in community activities. The team acknowledged that he had not been exposed to any other living options, but stated further they were concerned for the individual's safety if he lived in the community because he is independent and likes to walk about the neighborhood, but has few pedestrian skills. The team determined the most integrated setting for this individual was DSSLC, despite his preferences for community integration, and did not develop any strategies for exposing him to learning opportunities about living options, nor community employment. The only strategy developed for the obstacle of pedestrian safety was a training program that consisted of prompting him to stop at the crosswalk when going to evening activities on campus, rather than training that would allow him to learn pedestrian safety in a community setting. • For Individual #687, the PST indicated DSSLC was the most integrated setting, and noted her awareness of living options was minimal as she had not visited any community homes in the past year. Obstacles identified included the individual's friendliness and lack of "stranger danger," lack of generalized pedestrian skills off-campus (although on-campus pedestrian skills were described as good), and the possibility that she would have an increase in certain behaviors if she missed staff at the Facility. It was not clear that any of these would be significant obstacles with the development of an appropriate living option in the community. In any event, no strategies were developed by the team to address any of these.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	The Monitoring Team reviewed documents related to education and awareness activities and interviewed the Director of CFR, the Post-Move Monitor, the QMRP Educator and the Director of Program Coordination. In response to the document request for a list of all trainings/educational opportunities provided to individuals, families and LARs to enable them to make informed choices, the Facility provided a list of individuals who had made community tours from 3/12/10 – 1/31/11. While the list contained 72 names, this did not represent that 72 different individuals had the opportunity to make tours, as there were individuals who made two or three such excursions. Most striking, however, was the fact that since the date of the last site visit through 1/31/11, a period of nearly four months, only 11 individuals had participated in tours of community homes and programs, according to the documentation provided. This would appear to represent at least most of the opportunities provided over the past six months. The Director of CFR stated that he thought there might have been more tours, but that documentation was not available to substantiate this impression. Preparing Facility staff to engage individuals, families and LARs in discussions about community living is another essential ingredient in the provision of adequate education	Noncompliance

#	Provision	Assessment of Status	Compliance
		of these options. The community referral process was incorporated into new employee orientation. The Facility also maintained documentation on the participation of staff in tours and visits to community homes, which indicated that only 18 staff had participated in either a community tour or pre-placement visit from the time of the last site visit until 2/18/11. The addition of the two part-time positions in the Department of CFR was intended, in part, to enhance staff awareness and education. The annual MRA CLOIP process continued to comprise a significant portion of the Facility's overall plan for education and awareness, but perhaps should not be viewed as the primary vehicle to meet the learning needs of individuals who live at the Facility. The Monitoring Team reviewed a sample 39 CLOIP Worksheets completed for PSPs held in the month of March 2011. For 15 of the 39 (38%), the LAR did not allow the MRA Service Coordinator to provide the individual with information about living options. For 21 of the remaining 24 in which the MRA did engage the individual in the CLOIP, the MRA Service Coordinator documented the individual had no response, the individual's response was unknown and/or the individuals did not seem to comprehend the materials or information being offered. This would suggest that there should be some consideration given to assessing how the materials and information should be modified to better meet the needs of the individuals. On the other hand, the Monitoring Team was pleased to see a significant degree of involvement of Contract MRA staff in one PSP meeting during this site visit. There was good interactive discussion between the PST members and the MRA staff, with the former requesting information about community providers, processes, supports and services, and the latter serving an important technical assistance and educational role. Overall, DSSLC had taken minimal actions to increase education and awareness about community living options over the past six months. In the POI, the Facility stated it was developing a proposal for a more comprehensive and cohesive educational plan, but this was not yet available for review. This strategic plan should promote awareness, with assigned responsibilities, timelines and outcome measures. Partners in this effort should include all those with responsibility for education and training: the Director of CFR, the Post-Move Monitor, the QMRP Educator, the Competency Training and Development department at the Facility, the Contract MRA and other MRAs, with input from self-advocates at the Facility. PSTs should receive additional instruction as to how to develop an individualized education/awareness strategy for each individual that takes in to account their specific learning needs.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of	The Facility continued to take the position that the assessment for placement process is the Community Living Options Discussion Record (CLODR) that takes place at least annually as a part of the PSP as described in Texas DADS SSLC Policy 018: Most Integrated Setting Practices, 3/31/10. The Facility provided a list of approximately 566	Noncompliance

#	Provision	Assessment of Status	Compliance
	individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	individuals who had been assessed for placement between 3/1/10 and 2/28/11 using this definition. If the Community Living Options discussion was implemented in such a manner that it could be considered an effective assessment for placement, the Facility would have fulfilled this requirement. From observations and document reviews as described in Provisions F1e and T1b above, this did not yet appear to be the case. For example, as was noted in Provision F1e, PSTs sometimes made very different assessments regarding placement for individuals with very similar support needs. Many times, these decisions appeared to be based on LAR/family preference rather than on the actual support needs of the individual. Another important component of the assessment for placement process is to identify and address obstacles that might impede such placement. Provision T1b1 details the failure of the PSTs to adequately implement this portion of an assessment process. 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. These improvements should begin with a clarification and additional training for PSTs on their responsibility to assess each individual or the most integrated setting appropriate to their needs, combined with a focus on the ability of the PSTs to engage in critical thinking, interdisciplinary assessment and actual person-centered planning. This will require considerable staff training and mentoring.	
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 did not always ensure that PST identification and recommendation of an appropriate integrated community setting resulted in a timely placement within the 180 day timeframe required by Texas DADS SSLC Policy: Most Integrated Setting Practices 018.1, 3/31/10. The Monitoring Team reviewed the Community Placement Report, dated March 01, 2011. Of the five community placements that had occurred since 10/1/10, all were completed within the 180 day timeframe, but of the ten current active referrals, five had already exceeded the 180 days. The Facility should ensure that timeliness of actions related to referrals and community placements are included in its development of the quality assurance procedures required under Section T1f. The Facility was beginning to phase in a new and expanded CLDP process and format. The CLDP instructions for completion require that: 1. Development of the CLDP should begin at the time of the referral for alternate community placement and should continue past the transition date. 2. The CLDP should be completed using the person directed planning philosophy 3. PSTs will meet at various stages of the community transition process. 4. Deliberations from these meetings will be captured in the CLDP 5. Direction from the individual and/or LAR (if applicable) should be solicited and	Noncompliance

#	Provision	Assessment of Status	Compliance
		documented at each stage of the process As the Facility had only recently begun to phase in these improvements to the process, it was not possible to adequately assess compliance at this site visit. The Monitoring Team will look forward to reviewing the Facility's progress at the next visit.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The 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 PST did appear to rely heavily on the PSP and the assessments associated with the PSP to guide the identification of the essential and non-essential supports. 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 during the PSP planning meeting of the supports and services needed and desired in a community setting, as described in Section T1b, Section F1c and Section F2a. Examination of this element of the Settlement Agreement will therefore be contingent to some degree on a positive evaluation of these items at some point in the future. The Monitoring Team attended the single CLDP meeting held during the site visit, for Individual #618. While the meeting and process demonstrated continued improvement over previous visits in terms of thoroughness, the PST still failed to identify important issues in its listing of essential and non-essential supports. In developing a CLDP that takes advantage of the opportunities inherent in community living, it is also important that PST members be aware of the types of services and supports that are available in the community. In general, the PST tended to identify only those things that are currently provided at the Facility. This could result in many missed opportunities for individuals to have supports that expand on their experiences. For example, Individual #618 was blind. In the CLDP, the PST was not familiar with the potential to access services through the Deaf-Blind waiver, including an orientation and mobility service to assist the individual in acclimating to the new environments. When the Monitoring Team suggested this was a needed service, the MRA staff attending the meeting identified the potential resource to meet the need. There were also several health-related issues raised by the Monitoring Team's physician that had not been adequately identified or addressed by the PST. The Monitoring Team reviewed four recently completed CLDPs for individuals who had already moved to the community and the CLDP for Individual #178, who was to move to the community in the near future. The listing of essential and essential supports did not always adequately capture basic requirements for a successful transition. Examples	Noncompliance

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		included: • For Individual #178, it was not clear the PST had adequately identified nor addressed issues related to safety and freedom of access in the individual's new home, as described below in T1e. • For Individual #178, the CLDP assessments indicated the individual should be screened for atlantoaxial dislocation at least once every 10 years. There was no description of the symptoms, cause or potential complications of this spinal cord disorder. It was not clear whether the individual had ever been diagnosed with atlantoaxial instability, or was being undertaken merely as a screening. In either event, the provider should have been made aware of related precautions to take. • For Individual #685, the DSSLC Post-Move Monitor documented in the 45-day review that the CLDP document appeared inconsistent with the assessments upon which it was based and stated an intention to follow up with the PST at DSSLC to clear up these inconsistencies.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	For the one CLDP observed during the site visit, the PST did identify Facility staff to be responsible for each action that was specified during the meeting. For one of four CLDPs reviewed, the Facility did not assign specific Facility staff responsibility for each of the essential and non-essential supports. For this CLDP, the responsible person to provide an in-service on Individual #777's Physical and Nutritional Management Plan was listed as "Denton SSLC staff," rather than designating a staff by name. This lack of specificity may have contributed to the failure to provide this support in the required timeframe that was later documented by the Post-Move Monitor. (See T1e below.)	Noncompliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	The Monitoring Team reviewed the attendance signature sheets for four completed CLDPs for evidence that the individual and, as appropriate, the LAR had participated in the CLDP. All indicated the individual and/or LAR/family member had participated in the CLDP, and there was a brief narrative in the CLDP that described their participation in the transition planning process. The new CLDP format and process calls for solicitation and documentation of direction from the individual and/or LAR (if applicable) at each stage of the process. This was a positive direction, but the Facility had not yet fully implemented the new process. For two of the partial CLDPs using the new format (Individuals #384 and #232), there was not consistent documentation of the individual and/or LAR being consulted at each step of the process. The new CLDP format had a number of stages in which deliberations by the PST were to be recorded, including the date of referral, the date of APC/PMM/PST meeting and the dates of meetings to discuss pre-selection visits and provider selection. At each of these stages, it would be expected to have documentation that direction from the individual or LAR was solicited. For Individual #232, all of these sections of the CLDP	Noncompliance

#	Provision	Assessment of Status	Compliance
		were blank and provided no documentation as to the seeking of direction from the individual or family member. The Monitoring Team realizes the Facility was in the middle of phasing in the new format and anticipates these issues would be worked through in the process, especially given that earlier CLDPs had at least a brief summary of individual/LAR participation.	
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.	This component was found to be not in compliance. There was improvement in the Facility's process for ensuring the required 45-day comprehensive assessment documents were obtained and reflected in the CLDP documentation. Obtaining updated assessments from various professionals and ensuring they are available at the CLDP and for the use of the selected provider is an important step. However, as described in T1c1 above and T1e below, these were not being integrated into a comprehensive assessment in a manner that allowed for the CLDP to accurately reflect the needs and supports to be provided in the community setting. In order to be considered a current and comprehensive assessment of needs and supports, the findings and recommendations must be accurate and reflect all significant information the PST and the community provider would need to develop an appropriate transition plan. For example, for Individual #618 the Monitoring Team identified needs for mobility and orientation supports as well as health concerns that the team concurred with, but had failed to assess prior to the CLDP meeting.	Noncompliance
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	This component was found to be not in compliance. The Monitoring Team reviewed documentation of the MRA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for three individuals who had transitioned to the community since 10/1/10. These generally appeared to have been completed in a timely manner following the CLDP and prior to the actual transition date, per the completion date. The instrument also calls for the MRA to attest it has verified the provider is in good standing with DADS, using the DADS Quality Reporting System website, and to attach the printed verification. These were not attached to any of the instruments made available to the Monitoring Team for review. DSSLC should ensure that complete documentation is kept as required. The revised CLDP process requires the Facility to also complete its own pre-move site visit prior to the individual's transition date. A pre-move site visit for Individual #178 was held on 3/29/11. The Monitoring Team accompanied the APC, the individual and members of the individual's PST on the visit. In addition to checking the availability of the essential and non-essential services, certain PST members also provided in-service training to the provider staff. This team approach was to be commended. Although this approach to the pre-move site visit was commendable, certain aspects	Noncompliance

#	Provision	Assessment of Status	Compliance
		observed by the Monitoring Team called further into question the abilities of PSTs at DSSLC to assess the support needs of individuals and to adequately implement the full range of community living discharge planning needed to ensure successful transitions. It was noted the individual's room was to be on the second floor at the top of a relatively steep and long staircase. The individual, while able to walk, could not independently climb or descend the stairs, and required much staff assistance and a great deal of time to do both. It was reported by the provider staff that the individual had become much more adept at the process over the course of his trial visit, and they expected he would again over time. The provider staff and PST members had a prior conversation about putting a gate across the top of the stairs to prevent the individual from falling down the stairs. The discussion during this visit centered on whether to raise the height of the gate. There was no discussion as to whether the environment was appropriate for the individual, given that he could not have free access to his room, nor was there any discussion about emergency evacuation plans. The provider staff's room was on the first floor, so he would not be immediately available if a fire were to occur and the individual would be unable to exit the second floor, much less the home. The Monitoring Team questioned the APC as to whether these issues of access and safety had been discussed during the CLDP process, including after the trial visit, but she did not know. Further interviews with the Director of CFR and the Post-Move Monitor indicated they were unaware of the situation. There was no documentation to indicate the PST had considered this situation. This was very unfortunate, as the individual had clearly grown comfortable with the provider and liked the home. This was a failure of the CLDP process at many points. The PST failed to identify the need of the individual to have a single story home for the purposes of freedom of movement and overall safety. During the trial visit phase, the team failed to address the appropriateness of the physical environment. During the final CLDP meeting, the PST did not identify the potential concern. The pre-move site visit provided an additional opportunity to discover and address the issues, but the completed Pre-Move Site Review did not raise these concerns, other than to note the safety gate at the top of the stairs needed to be raised. There was additional evidence discovered in the review of the PMM process to indicate the Facility was not consistently implementing the CLDP and ensuring all supports and services were in place. For three of four individuals, the PMM documentation reflected the failure of DSSLC to provide some essential support in a timely manner. For example: • For Individuals #406 and #795, it was documented that the Post Move-Monitor delivered the adaptive dining equipment specified as an essential support in the CLDPs at the time of the 7-day visit. These supports should have been in place	

#	Provision	Assessment of Status	Compliance
		prior to the individual leaving Facility, according to policy. At the very least, this equipment should have accompanied the individual upon placement. • For Individual #406, neither the nursing in-services related to falls, pain, psychotropic medication side effects and oral hygiene, nor the in-service on diet texture and the dining plan had been completed by the time of the 7-day visit. These had been identified as essential supports in the CLDP. • For Individual #777, the Post-Move Monitor documented at the 7-day visit that essential supports, including in-services on the Positive Behavior Support Plan and the Physical and Nutritional Management Plan, had not been provided by DSSLC as required. In the Action Taken notes, the Post-Move Monitor further documented these supports were not provided until 12/21/10, four days after the individual transitioned to the new home. The Monitoring Team will look forward to reviewing this process when it is fully and consistently implemented.	
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 Facility did not have quality assurance policies, procedures and/or processes to ensure that community living discharge plans were developed, and that the Facility implemented the portions of the plans for which the Facility was responsible. The reviews of the CLDPs from this site visit, as described in sections T1d and T1e above, and of the progress of referrals, as described in Section T1c, would suggest the Facility needed to develop or otherwise promulgate written quality assurance procedures that would ensure CLDPs are tracked from the process of referral through move to the community. This should include written procedures for ensuring, at a minimum: • PST recommendations for community living for individuals result in a timely meeting with the Designated MRA to consider making the referral; • Referrals are routinely tracked and are completed within the 180 day timeframe unless a waiver is granted; • CLDPs routinely 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.	Noncompliance
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an	This component was found to be not in compliance. In response to the document request for this item, the Facility provided a spreadsheet with eight names of individuals who had a preference for community placement. The reasons listed the PST did not make such a referral included LAR choice for five individuals, exploring community options for one, prefers only family/family not available for one, and behavior/psychiatric for one. The Facility indicated it had not done any analysis of obstacles, but expected to begin a	Noncompliance

#	Provision	Assessment of Status	Compliance
	annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	more comprehensive approach to this requirement following some anticipated guidance from the DADS State Office. The Monitoring Team did not find this current approach to adequately address the requirements of this component. It is expected that the Facility will gather obstacle data on a more comprehensive basis, not just for individuals who have indicated a preference for community placement but were not referred. It is also expected the Facility will 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 to DADS. 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. DADS had issued its first annual Obstacles Report for the State Supported Living Centers in October 2010, which provided guidance to the Centers as to the methodology and categories of obstacles to be used in order to ensure the State Office receives comparable and consistent data from each one. The Monitoring Team found the report to provide excellent guidance to the Facility regarding the types of obstacle data to be collected, such that they may be collated to provide an accurate picture of the obstacles to be addressed both in the catchment areas and the state as a whole. The methodology continued to rely heavily, as appropriate, on the PSTs to identify the obstacles on an individualized basis for each person. It also referenced the newly revised PSP process that was currently being introduced to the facilities, and stated that specific direction would be given to the PSTs under this new process to address the content of the Living Options discussion to include both the individual's and his/her LARs awareness, experience, and exposure to alternate living arrangements. The revised process was also described as including "a Personal Focus Assessment that will provide the PST with the individual's interest in pursuing alternate community placement, along with a geographic location for possible future placement, prior to the annual planning meeting. This will provide the PSTs with three months to explore the identified geographic location for obstacle identification prior to the Living Options discussion at the annual PST meeting." The PSTs will need further training to adequately perform these tasks that form the basis for obstacle identification.	
T1h	Commencing six months from the	The Facility issued a Community Placement Report on March 01, 2011, covering the	Substantial

#	Provision	Assessment of Status	Compliance
	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.	period of 9/1/2101–3/1/2011. The report was in the standardized format as prescribed by DADS State Office. It listed: • Five community placements • Ten current referrals • Zero rescinded referrals • Zero individual prefers community, not referred-LAR choice • One individual prefers community, not referred-other reason • Zero LAR prefers community – not referred The Monitoring Team concurred with the Facility's assertion of substantial compliance for this provision. However, as described in T1b1 and F1e, PSTs did not always understand their responsibilities in identification of the most integrated setting appropriate to an individual's needs, and frequently deferred their own assessment based on the stated preference of the LAR. While the Community Placement Report indicated that there were no individuals included in that category, the Facility reported elsewhere in the document request that there were individuals who had requested community living, but were not referred due to LAR choice. This is further described in T1g above regarding the list of obstacles. Upon interview, the Director of CFR indicated that at least some of the individuals on this latter list were indeed not referred due to LAR choice. The Facility should ensure that these data are accurately reflected in the Community Placement Report.	Compliance
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.	Noncompliance
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two	This component was found to be not in compliance. The Facility had indicated it was not in compliance in the area of PMM. The Monitoring Team interviewed the Post-Move Monitor and reviewed the PMM checklists for four individuals, all of whom received	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	monitoring by the DSSLC Post-Move Monitor. The Monitoring Team found that the PMM Checklists were generally being completed in a timely manner. For one of the four individuals, the 7-Day visit did not occur until the fifteenth day. There were extenuating circumstances in that there was inclement weather and the Post-Move Monitor was ill. The 7-Day visit was due by 2/3/11, and had been planned for 2/1/11. The Post-Move Monitor provided email evidence that she contacted the provider on 2/1/11 when the visit could not be made due to an ice storm, and re-scheduled for 2/3/11. The Post-Move Monitor subsequently became ill and the visit was not made until 2/11/11. The Facility needed to develop a back-up plan for instances such as these when the Post-Move Monitor may be unavailable, in recognition of how critical this early transition period can be. The potential for PMM visits to be missed when the process takes place across catchment areas was an area of concern during a previous site visit, but this appears to have been resolved through a tracking process implemented by the DADS state office. In addition, it was reported that the Facility would provide monitoring only for individuals who transitioned from DSSLC beginning on 4/1/11. There was considerable progress noted in the process used to complete the PMM Checklists. The Post-Move Monitor was to be commended for the improvements noted, especially in the enhanced thoroughness and documentation of follow-up to issues discovered in the PMM reviews. In general, the PMM Checklists reviewed during this compliance visit provided in-depth information that painted a picture of the individual's adjustment, although there were still rare instances in which the Post-Move Monitor failed to document carefully and/or follow up as needed. For example, for Individual #406, some items were not completed on the 7-Day PMM Checklist, including whether or not there staff training documentation for medical, behavioral consideration and communication and adaptive aids. Some additional deficiencies in the process remained. The Post-Move Monitor did not always visit each of the sites in which supports were to be provided. The PMM process was designed to be intensive during the critical 90 day period following transition. The Post-Move Monitor did observe the individuals in their new home environments at all 7-day visits, but for three of four individuals, the day program was not visited until the 45-day visit. The Post-Move Monitor must personally ensure that supports are available and being provided in the appropriate and prescribed manner in all sites in which the supports are called for at each of the required visits. The draft DADS Policy 018: Most Integrated Setting Practices, dated variously 1/27/10 and 0/00/11, provided in Section VII.B. that on-site reviews of both the residential and program sites are required. The Monitoring Team concurs with this requirement.	

#	Provision	Assessment of Status	Compliance
		The Monitoring Team interviewed the Post-Move Monitor regarding these issues related to follow-up and documentation. In general, the Post-Move Monitor had taken some actions and provided emails and phone logs that would document additional follow-up. In addition to ensuring that all necessary follow-up is completed, the Post-Move Monitor should continue to carefully document the follow-up, including date and response to action taken. Emails and phone logs related to the follow-up should be attached, maintaining all documentation related to PMM as a complete record.	
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.	This component was not rated. No PMM visits were scheduled during this site visit to provide a basis for assessment of compliance.	Not Rated
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.	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. The Facility reported having only one person in this category.	Not Rated
T4	**Alternate Discharges -**		Not Rated

#	Provision	Assessment of Status	Compliance
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	This provision was not rated. The Facility reported that no individuals have been discharged pursuant to an alternative discharge as defined in the Settlement Agreement. The Facility did not currently have a policy and procedure in place describing how it would comply with the requirements of this provision if such a circumstance arose. As it is possible that such an alternative discharge could occur at any time, it is suggested a Facility policy and procedure should be in place to identify how the Facility will identify alternate discharges and implement discharge procedures consistent with CMS-required discharge planning procedures. The draft DADS Policy 018: Most Integrated Setting Practices, dated variously 1/27/10 and 0/00/11, Section VII, addresses the requirements for alternate discharges and provides a template for discharge summaries for these individuals in Exhibit F. Once formally promulgated, this policy should be sufficient to provide guidance for the development of the Facility-level policy and procedure.	Not Rated

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

1. The State and the Facility should review the guidelines included in their internal revised Section T monitoring tools to ensure they are consistent with the requirements of the SA, the ADA and the Olmstead decision.
2. 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. The Monitoring Team recommends that the Facility implement a formal curriculum for "planning my future" that is incorporated into the overall active treatment program on an ongoing and regular basis. Information may be found at: http://www.ilr.cornell.edu/edi/pcp/courses.html.

3. There should be some consideration given to assessing how the CLOIP materials and information should be modified to better meet the needs of the individuals. MRA CLOIP staff may benefit from additional training in recognizing opportunities to continue a conversation about community living and how to appropriately address them.
4. The Facility should develop a comprehensive strategic plan for education on community living options with assigned responsibilities, timelines and outcome measures. PSTs should receive additional instruction as to how to develop an individualized education/awareness strategy for each individual that takes in to account their specific learning needs.
5. The Facility should ensure that data regarding individuals who are not referred for community living solely due to LAR choice are accurately reflected in the Community Placement Report.
6. The Facility should ensure that timeliness of actions related to referrals and community placements are included in its development of the quality assurance procedures required under Section T1f.
7. Facility policy and procedure should specify the expectations that Facility staff have responsibility to monitor or follow up with the designated provider staff to ensure implementation and/or timeliness of the supports specified in the CLDP. The implementation of the Facility Pre-Move Site Visit may provide an avenue for designating the responsibility of Facility staff.
8. The Post-Move Monitor must personally ensure that all supports are available and being provided in the appropriate and prescribed manner in all sites in which the supports are called for, and at each of the required visits.
9. In addition to ensuring that all necessary follow-up is completed, the Post-Move Monitor should continue to carefully document the follow-up by filling in the Action/Follow-up section of the Checklist, including date and response to action taken. Additionally, emails and phone logs related to the follow-up should be attached. It is also recommended that DADS state office incorporate its expectations regarding this documentation into its statewide policy and procedure.
10. The Facility should develop a back-up plan to ensure PMM visits can be made on a timely basis in the event the Post-Move Monitor is unavailable due to extenuating circumstances.

11. 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.

The draft DADS Policy 018: Most Integrated Setting Practices, dated variously 1/27/10 and 0/00/11, Section VII, addresses the requirements for alternate discharges and provides a template for discharge summaries for these individuals in Exhibit F. Once formally promulgated, this policy should be sufficient to provide guidance for the development of the Facility-level policy and procedure.

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Denton State Supported Living Center (DSSLC) Plan of Improvement (POI), updated 03/15/2011 2. DSSLC's Report for Monitors, dated March 28, 2011 3. Program Specialist job description 4. List of Legal Guardians Assigned for 368 individuals, dated March 31, 2011 5. Prioritized list of 185 individuals who are in need of an LAR, undated 6. List of five individuals for whom a Legally Authorized Representative (LAR) had been obtained since 10/1/10 7. Personal Support Plans and Rights Assessments for Individuals #295, #606, #621, #645, and #687 8. DSSLC Policy and Procedure Client Management-04 Legal Consent, dated June 1. 2006 9. DSSLC Policy and Procedure Client Management-30 Guardianship, dated March 1, 2009 10. Draft DADS Policy Number: 019 Guardianship, undated 11. DADS draft Policy Number: 019 Rights and Protection (including Consent & Guardianship), dated 6/11/10 **People Interviewed:** 8. Andy Maher, Director of Consumer and Family Relations (CFR) 9. Sezer Ruzek, Human Rights Officer (HRO) **10.** Pam Garrett, HRO **Meetings Attended/Observations:** 1. PSPs for 2 Individuals: Individuals #691, #293
	Facility Self-Assessment: DSSLC indicated it was not yet in compliance with any of the provisions for Section U. The Monitoring Team concurred with this assessment. The POI indicated that the DADS State Office workgroup is continuing to work on development of statewide policies, procedures and practices that will provide guidance to the facilities in these requirements of the Settlement Agreement, and that it was awaiting this final guidance prior to implementing significant changes. The 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, but these reported actions were not always consistent with the information obtained during interviews during the site visit. For example, the POI indicated the HROs would begin arranging workshops about guardianship, for family members, advocates, current guardians, PST members and others, as an interim training measure. This was projected to begin on 3/01/2011 and its completion status was denoted as "in process." During interview with the HROs, no such activity was reported. The POI also cited as a completed action step that the job descriptions of the HROs included a description of their role as guardianship specialists. The Program Specialist job description provided to the Monitoring Team for review did not reference guardianship.

	Summary of Monitor's Assessment: The Monitoring Team reviewed the DSSLC POI. DSSLC indicated it was not yet in compliance with any of the provisions for Section U. The Monitoring Team concurred with this assessment. The POI indicated that the DADS State Office workgroup is continuing to work on development of statewide policies, procedures and practices that will provide guidance to the facilities in these requirements of the SA. During on-site interview, the Facility reported it was awaiting this final guidance prior to implementing significant changes. The Monitoring Team reviewed a sample of documents in order to be able to assess progress, if any, from the last compliance tour and provide any additional recommendations that may be helpful to the Facility when it does undertake further action in these provisions. The findings are as follows: **Provision U1:** This provision was determined to be not in compliance. The HROs had been designated with the responsibility for the requirements of this provision, but, as noted above, their job descriptions did not yet reflect all of these. The Facility did maintain a list of individuals needing an LAR, but there was still no standardized approach to assessing and determining the actual need for an LAR on an individualized basis that was consistent with commonly accepted professional standards of practice. The most recent version of a draft statewide policy did not contain any substantial guidance for the Personal Support Teams (PSTs) in terms of a standardized tool and/or process, a much needed resource in the opinion of the Monitoring Team. **Provision U2:** This provision was determined to be not in compliance. The HROs had taken some initial steps toward furthering their own education regarding guardianship in preparation for an expanded role in efforts to obtain LARs for individuals lacking LARs. This was a positive step towards acquiring the knowledge and expertise needed to assist both individuals and LARs in the guardianship process. There was otherwise little activity toward the solicitation of guardians for individuals during this review period. Only five guardians had been obtained, and several of these were successor guardians for individuals who had previously been adjudicated as in need of an LAR. It remained appropriate that the Facility has not undertaken a large-scale effort to solicit guardians until it can be assured that its processes for assessing the actual need for guardianship are individualized and completed in a manner in accordance with commonly accepted professional standards of practice.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a	DSSLC did not have a policy and procedure describing its processes for developing and maintaining 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. The Facility reported that a statewide workgroup was continuing to work on a draft policy to implement the requirements of this provision. The group last met in January 2011. The HROs further reported that there is a June 1, 2011 deadline for submission of revisions to be included for the final review. The Monitoring Team requested a copy of the current draft statewide policy and received	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	DADS Policy 019: Guardianship. It was undated. This draft policy had changed rather significantly from a draft that had been previously circulated for review by the Monitors, Policy Number: 019 Rights and Protection (including Consent & Guardianship), dated 6/11/10. The stated purpose of this new draft of Policy 019 was "…to ensure that individuals residing in State Supported Living Centers (SSLCs) and their legally authorized representatives (LARs) and correspondents are made aware of guardianship services available in Texas and to identify those individuals without a LAR who would benefit from having an LAR to help them make decisions regarding treatment and programming." The draft policy did not provide substantial guidance to the Facilities and the PSTs in how to assess an individual's need for guardianship. No standardized tool or process was described for PSTs to use in making these determinations. Rather, it states "…the personal support team (PST) will discuss the individual's capacity/incapacity to make decisions regarding the individual's health and welfare." For individuals who do not currently have an LAR, the PST is instructed as follows: "If the individual does not have a LAR, is unable to give legally adequate consent, and is able to express his/her wishes verbally/gesturally/via a communication device/etc., the PST will need to discuss with the individual the role of a LAR as it relates to decision making, and make a determination of whether or not the individual would benefit from a LAR." "If the individual does not have a LAR, is unable to give legally adequate consent, and is unable to express his/her wishes verbally/gesturally/via a communication device/etc., the PST will need to deliberate on the appropriateness of a LAR for the individual…" In the previously circulated draft of the DADS draft Policy Number: 019 Rights and Protection (including Consent & Guardianship), the state had offered considerably more specific guidance for the teams, a much needed resource in the opinion of the Monitoring Team as had been described in prior reports. For example, the previous draft had included the use of specific standardized tools for assessing differential levels of capacity to make decisions. The current draft did not. DADS should ensure the new version of the policy will also provide the PSTs with adequate guidance. Facility PSTs continued to need such guidance, as well as training, from DADS to prescribe a process for how an assessment should be accomplished 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. During this site visit, the PSTs were not using an individualized assessment process to determine that an individual was in need of an LAR or to what extent or for what discrete purposes	

#	Provision	Assessment of Status	Compliance
		guardianship was required. On the one hand, the Facility provided the PALS assessment in response to the document request for the tool it used to evaluate functional decision-making capacity, but, on the other, it also responded that it did not have a tool for this purpose. The PSTs continued to address the ability of an individual to provide informed consent in the annual Rights Assessment, but this process was not predicated on any objective criteria. The Monitoring Team reviewed five recent PSPs and accompanying Rights Assessments that had occurred from 12/10-2/11. For five of five PSPs (100%), the Rights Assessment concluded the individual was unable to give informed consent in all areas, but did not offer any specific basis for this determination in the way of an individualized assessment of the individual's decision-making capacity. The HROs reported the Rights Assessment currently being used was being updated, but it was not clear how this might address the differential assessment of the need for assistance with decision-making. The Monitoring Team looks forward to review of this updated tool in the future. DSSLC had maintained a prioritized list of individuals who did not have a current guardian. The list was undated and included the names of 185 individuals. There was no explanation of the prioritization process attached to this list, but the HROs indicated this process was unchanged from that in use during the last compliance visit in September 2010. They stated a prioritization process was to be included in the expected statewide policy and that a local policy would be developed once this final statewide version was received. A review of the draft policy indicated a prioritization process was incorporated. The current prioritized list was not always consistent with another list provided to the Monitoring Team, entitled Legal Guardians Assigned dated March 31, 2011. A comparison of just the first page of the list of those without guardians with the list of those who had Legal Guardians assigned revealed that two individuals were listed both as being in need of a guardian and as having a named guardian. In addition, the Legal Guardians Assigned document listed 368 individuals, but a number of them also had a notation of "no guardian." DSSLC should review the two lists in order to ensure it has accurate and up-to-date guardianship for each individual.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the	DSSLC reported that responsibility for this provision was vested with the HROs. The Facility POI cited as a completed action step that the job descriptions of the HROs included a description of their role as guardianship specialists. The Program Specialist job description provided to the Monitoring Team for review did not reference guardianship. Upon final issuance of the statewide policy and development/revision of	Noncompliance

#	Provision	Assessment of Status	Compliance
	Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	the local implementation policy and procedures, the HRO job descriptions should also be revised to address their guardianship responsibilities. The HROs reported they had taken on responsibility for guardianship issues, including tracking of expiring guardianships, assisting with documentation for guardianship applications and renewals and planning for successor guardianships. Both staff reported they had attended trainings related to their guardianship responsibilities, including an inservice from the Denton County Probate Court investigator and a training by the local guardianship agency, Health Services of North Texas. This was a positive step towards acquiring the knowledge and expertise needed to assist both individuals and LARs in the guardianship process. DADS draft Policy 019 specified that, as the Guardianship Coordinators, the HROs would play a significant role 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 HROs stated they were in the process of developing the guardianship committee the new statewide policy draft required. In addition, the draft policy called for the facility Guardianship Coordinator to: • Work closely with the facility Parent Association (if applicable) and provide information to the association members regarding local guardianship programs and resources at the facility Parent Association meetings. • Work with local guardianship programs, sharing appropriate information regarding individuals requesting an LAR, and soliciting information regarding community supports to assist with guardianship fees, court costs, etc. • Organize/host an Annual Guardianship In-service to individuals, families, facility staff, etc. to discuss guardianship needs, supports, and services. DSSLC did not report any organized efforts undertaken to obtain LARs for individuals lacking LARs, or to provide education in the process, during this review period, with one exception. They made a presentation at the parents' association meeting in February 2011 to inform family members of upcoming changes related to the anticipated new statewide policy, including the need for the Guardianship Committee. They also reported DADS State Office had sent letters to current guardians around the beginning of this year, specifying guardianship duties. It was appropriate that the Facility had not undertaken a large-scale effort to solicit guardians until it can be assured that its processes for assessing the actual need for guardianship are individualized and completed in a manner in accordance with commonly accepted professional standards of practice. It is also appropriate that no large-scale effort to solicit guardians is made until the Facility has further developed	

#	Provision	Assessment of Status	Compliance
		policy and procedure regarding the criteria for and education of potential guardians as described above. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a pre-requisite.	

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

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. DADS should ensure the pending statewide DADS Policy Number: 019 Guardianship will provide the PSTs with adequate guidance in this area.
2. DSSLC should review the current Legal Guardians Assigned list against the prioritized list of those in need of an LAR to ensure it has accurate and up-to-date guardianship for each individual.
3. Once the statewide policy and assessment process has been finalized, DSSLC should refine and develop facility-specific policies and procedures to operationalize the requirements. The Facility should ensure its policy and procedure, once developed, include:
   - 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. Upon final issuance of the statewide policy and development/revision of the local implementation policy and procedures, the HRO job descriptions should also be revised to address their guardianship responsibilities.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Denton State Supported Living Center (DSSLC) Plan of Improvement (POI), updated 03/15/2011 2. DSSLC's Report for Monitors, dated March 28, 2011 3. DADS Policy 020.1 Recordkeeping Practices dated 03/05/10 4. DADS Policy Draft (undated) 006 – Risk Management 5. DSSLC Policy CMGMT-12.01 Personal Support Planning Process dated 01/03/11 6. DSSLC Policy CMGMT -14 At Risk Individuals 1/1/11 7. DSSLC Policy: Client Management-25 Recordkeeping Practices Rev. 05-18-2010 8. DSSLC Index of Policies and Procedures Manual 9. DSSLC Policy CMGMT-24: Psychological Services (11/30/10) 10. DSSLC Personal Support Planning Process, Policy/Number: CMGT-12.01, Date: 1/3/11, Supersedes: CMGMT-12 11. DSSLC Procedures for Distribution of Policies to Employees 12. Records Audits and emails listing corrective actions required for Individuals #22, #61, #95, #111, #123, #189, #218, #460, #553, #585, #734, #738, #742, and #743 13. Unified Record for Individuals #12 and #772 14. Minutes of QA/QI Council Meeting of 3/31/11 15. QA/QI Council Meeting Data Analysis Report 10/21/10, 1/20/10, 11/18/10, and 3/31/11 16. Meeting minutes and sign in sheets from audit training for records clerks 3/1/11 **People Interviewed:** 1. Melissia Steele, Unified Records Coordinator (URC) 2. Betsy Knight, Client Records Administrator 3. Lori Powell, Director of Quality Assurance 4. Group interview with Dr. Stephen Kubala, Director of Medical Services, Randy Spence, Director of Behavioral Services, and Donna Groves, Director of Habilitation 5. Joy Sibley, Communication/Speech Services 6. Several nurses 7. Wes Knox, Data Analyst 8. DCPs at homes 522A and 526D **Meetings Attended/Observations:** 1. PSP Annual Planning Meeting for Individual #772
	Facility Self-Assessment: The Facility reported that compliance had not yet been achieved for any provision of this Section but identified actions and accomplishments that had occurred. Provision V.1: The Facility reported that 100% of Active Records had been converted into the new format.

	Individual Notebooks had been implemented. Provision V.2: The Facility reported that State policies have been received and local policies developed. The Monitoring Team noted several newly developed policies; however, many more policies must be developed or revised to implement all provisions of the SA. Provision V.3: The Facility reported that tracking and trending of audits had begun. A new process had been implemented in which Records Clerks review records from sister units, with inter-rater reliability checks by the Unified Records Coordinator. Provision V.4: The Facility reported it has not had adequate monitoring to show compliance. The Monitoring Team found the Facility has no system in place to assess compliance with this provision.
	Summary of Monitor's Assessment: For each individual, the Facility had an active record, a master record, and an individual notebook. Individual notebooks were implemented at the end of January 2011. The Facility had converted all records into the revised format. Nevertheless, records sampled were not complete, some documents were misfiled, and there were gaps at the bottoms of many integrated progress notes and observation notes. In addition to the unified record, the Facility had a share drive that allows sharing of assessments so they are available to all clinicians and the QMRP on an individual's PST. Because many assessments were not posted to the drive timely, this system was not as useful as it could be. The process for auditing records had recently expanded to include audits by Records Clerks of records in sister units, with independent inter-rater reliability checks by the Unified Records Coordinator. Emails were to staff who were responsible for documents that required corrections, and the URC tracked reports of corrections completed and checked records to confirm the corrections were in place. A database of corrections needed and made had been implemented to track corrective actions and ensure they were completed. This was an excellent process. In addition to the unified record, the Facility had a share drive that allows sharing of assessments so they are available to all clinicians and the QMRP on an individual's PST. However, assessments were frequently not entered timely and therefore could not routinely be used for planning supports and services. The Facility did not have a process in place to monitor and evaluate how records are used. Through interviews and review of documents, the Monitoring Team found indications that staff used the information in records as they were considering supports and services but also that materials were missing or misfiled, or were filed and posted too late to be used for decisions. The Facility had developed or revised a large number of policies since the last compliance visit. New and revised policies addressed medical services, psychiatric service, psychology and behavioral services, the PSP process, the identification of risk and how risk will be addressed, quality assurance, and protection from harm and incident management. This active development of policies is commendable. Nevertheless,

	there are other policies that must be developed. Although no provisions of this Section were yet in compliance, significant progress had occurred in many areas.

#	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.	For each individual, the Facility had an active record, a master record, and an individual notebook. Individual notebooks were implemented at the end of January 2011. The records had all been converted to the revised format. In general, they were more organized, easier to find documents, and in better condition than during the baseline visit. Active records were generally found in two binders, although some records required more binders. One binder was the program record; the other was the medical record. A Record Order & Guidelines provided a table of contents for each binder. An orange sticker is put on the outside of the binder that contains physician orders and integrated progress notes. However, medical and health related information continued to be located in at least three separate sections of the record. Some individuals' records were contained in as many as five binders. The Monitoring Team independently reviewed the unified records for Individuals #12 and #772 in detail to audit completeness and accuracy of filing. For both individuals, the active record, master record, and individual notebook were checked. For the active record and individual notebook, the Monitoring Team identified which items were required (depending on individual, some items can be not applicable), which required items were present, and which were absent. In addition, the Monitoring Team rated other requirements of Appendix D, such as legibility and appropriate error correction. For Individual #12, 38 of 63 (58%) documents identified by the Monitoring Team as required in the active record were present. For the individual notebook, nine of 12 required documents (75%) were present. Examples of errors in the record included: • The social history and invitational letter to correspondents were missing. • Several items were missing from the correct tabs but were found elsewhere in the record, including an Emergency Restrictive Practice Form and a water safety assessment. • A consent for psychotropic medications that stated a date approved by the Human Rights Committee (HRC) was found appropriately filed in the Consents tab, but there was no HRC Referral form in the Rights tab.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Many pages in the observation notes had gaps at the bottom of the pages. • Not all required behavior data sheets were found in the individual notebook. For Individual #722, 46 of 63 (73%) documents identified by the Monitoring Team as required in the active record were present. For the individual notebook, 10 of 11 required documents (91%) were present. Examples of errors in the record included: • The psychological assessment was missing from the Behavior Services tab. • Consent for the PBSP was filed in the Behavior Services tab rather than in the Consents tab. • The health risk assessment was not in the record. • There were gaps at the bottoms of most pages in the observation notes. There were also systemic issues remaining for which practices need to be defined, policy or procedure established if necessary, and staff trained. For example, the Monitoring Team was provided with 14 files that were represented to be complete documentation for those 14 instances of medical restraint. There was very little similarity in documentation file to file leaving the Monitoring Team with the impression that DSSLC did not have standardized work processes for the use of medical restraints. In addition, there did not appear to be any standard methodology for the filing of medical restraint information in the record. Upon interview, three different administrators provided three different answers when asked "where in the record would I find documentation regarding medical restraint." In Nursing records, the legibility of the content of the notes, signatures, and titles showed little improvement since the last review. The time and discipline writing the notes were not always present. Both maritime and military times were used. For continuity one or the other method of documenting time should be used consistently. When asked, direct care staff at homes 522A and 526D were able to go directly to the individual notebooks and to locate the PNMP and PBSP immediately, as well as to show where the data sheets were or should be. Management of records had been brought together under the Department of Quality Assurance. This should provide an opportunity to enhance coordination of records. The Facility had a share drive that allows sharing of assessments so they are available to all clinicians and the QMRP on an individual's PST. DSSLC Personal Support Planning Process, Policy CMGT-12.01 requires that assessments be placed in the folder for the individual on the S: drive no later than five working days prior to the initial PST meeting and requires PST members to review all assessments. This provides an excellent	

#	Provision	Assessment of Status	Compliance
		opportunity to share information and prepare for an integrated planning discussion. Unfortunately, the promise of this system was not yet fully realized. Assessments often did not meet this policy-required timeframe and too frequently were not available to team members until they arrive at the meeting. In some cases they were not available, in written form until after the PSP meeting. The Monitoring Team reviewed the PSP Assessment Tracking log for eight individuals (3567, #594, #571, #713, #782, #339, #391, and #335) for February, 2011 PSP meetings. The log identified 53 needed assessments. Six (11%) were presented at the meeting. Eight (15%) were not available until after the meeting. Ten (19%) were available before the meeting but after the policy required due date raising doubt as to their usefulness in PSP planning meeting preparation. Twenty-four (45%) were not available within a timeframe that would facilitate integrated discussion and planning. The Facility needs to develop a process to ensure and monitor posting of assessments on the share drive and to assess whether PST members access and review the information.	
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.	The Facility had developed or revised a large number of policies since the last compliance visit. This active development of policies is commendable. • New and revised policies addressed medical services, psychiatric service, psychology and behavioral services, the PSP process, the identification of risk and how risk will be addressed, quality assurance, and protection from harm and incident management. • Since the last review the State Nursing Workgroup had finalized (February 2011) several nursing policies/procedures/protocols: Competency Based Training Curriculum-Agency/Contract Nurses, Nursing Documentation Guidelines, Pre-treatment and post-Sedation Monitoring, Management of Acute Illness and Injury, Seizure Management, and Medication Administration Guidelines. Review of these policies/procedures/protocols demonstrated significant improvement over the previous policies/procedures/protocols. • The Facility had developed a new Personal Support Plan Process policy related to transition and discharge processes. This was generally consistent with state-level most integrated setting policies. There are other policies that must be developed. Some of these would address individual rights, guardianship, and consent, for which the Facility is awaiting a policy from DADS and will then need to develop Facility policy consistent with state policy. Furthermore, policies need to be revised to ensure they provide the intended guidance. For example, dental policies are vague and do not enable a comprehensive understanding of how dental practices are provided.	Noncompliance
V3	Commencing within six months of	DSSLC had initiated a robust audit process.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Beginning during February 2011, records clerks are doing audits. The URC showed meeting minutes and sign in sheets from 3/1/11 training for records clerks. Each of the 12 records clerks does one audit per month at a sister unit and the URC does five. Of the records reviewed by the URC, four are inter-rater reliability checks in which the URC selects and audits a record that a records clerk also audits; one is an additional record not audited by a records clerk. To pick records to audit, the URC first goes through tracking sheet, looks at last date audits were done, and picks units with the oldest times since last audit. She then selects someone she has not audited. If all records are present for the person (which is usual), that individual's record is audited; if records are gone (e.g. at clinic) someone else is audited. When concerns about a record have been raised, this record may be added to the sample. While this process provides for the number of audits required by this provision, it does not produce random samples as required by the provision. The Facility should develop a process for random selection of records for review. The URC had a schedule to rotate which record clerks will have inter-rater reliability checks each month. There is not yet a system for randomization of the records selected for audit by the records clerks. Findings of audits were noted on the Active Record Order & Guidelines and on the Individual Notebook & Guidelines forms. Monitors documented presence or absence and date of documents in the active record. Because Individual Notebooks had only been implemented since February, audits reviewed by the Monitoring Team did not include information on those. The URC sent emails to staff who were responsible for documents that required corrections (such as filing missing documents, purging out-of-date documents and replacing them with current documents, and filing documents in the correct places in the record). The responsible staff were instructed to send documentation of what was corrected. The URC, upon receiving documentation, checked the record to ensure the correction had actually be done (and had been done correctly). This was an excellent process. For items that could not be corrected (such as missing observation notes that would rely on memory to reconstruct past events), the corrective action emails provide information intended to reduce reoccurrence of the same errors.	

#	Provision	Assessment of Status	Compliance
		A database had been initiated on 3/1/11 to track corrective actions and ensure they were completed. The database included date of audit, date email sent, date corrected, date the corrected record was checked by the URC, and additional corrective actions needed. The Monitoring Team reviewed audit forms by checking the Settlement Agreement Cross Referenced with ICF-MR Standards forms (the audit forms) for two individuals against the notes for those audits on the Active Record Order & Guidelines forms. • For Individual #123: o All items identified for correction in the audit were noted on the Corrective Action Plan (CAP) email. o Not all items could be corrected. For example, the responsible person was appropriately informed that observation notes for a range of dates was missing but should not be entered late. o Several documents were missing from the record but the audit form was marked Y for "complete." • For Individual #189: o All items identified for correction in the audit except "Flowsheet for ATPs" were noted in the CAP email. o Several documents were misfiled according to the notes on the Record Order & Guidelines, but the audit form was marked Y for "Accurate." o Several documents were not current according to the notes on the Record Order & Guidelines, but the audit form was marked Y for "Current." The Monitoring Team checked the contents of the master record against the Master Record Purging Schedule and found both records to include the required information. For the two records: • Two of two records (100%) included an active record, master record, and individual notebook. • Two of two records (100%) were legible. • Zero of two records (0%) contained all required documents. • Zero of two records (0%) had all documents filed correctly. • In one of two documents (50%), errors were correctly documented with scratch-through line, initials, and date. The Facility maintained a database of the ratings by item from the audit forms. Both primary and inter-rater reliability audits were entered, so that those records that had inter-rater reliability checks were counted, and their information was added, twice. The Facility should separate data from primary and inter-rater reliability audits.	

#	Provision	Assessment of Status	Compliance
		Data from audits was presented to the QA/QI Council. Data presented included graphs of percent of overall compliance with the monitoring tool for Section V of the SA for the period of June 2010 through December 2010 and a statement of the percentages for January and February 2011. A graph was provided of compliance for selected elements for January and February 2011, including: • There is a unified record for each individual. • Each component of the unified record is consistent with Appendix D of the SA. Data presented to the QA/QI Council on consistency with Appendix D showed less than 20% of audited records were found to be consistent with requirements. The Unified Records Coordinator reported that was primarily due to problems with legibility; she stated she had been working on this with Dr. Kubala and was seeing improvement. The Monitoring Team recognizes that the audit system is providing data that can be useful for determining systemic improvements. At this time, the audit process was still in development and the records system was too new for systemic improvement initiatives to be identified and undertaken; the QA/QI Council is expected to continue to track data on records and to determine need for improvements in order to improve compliance with the requirements of Appendix D and ensure the records provide accurate, complete, and accessible information that can be used to make decisions.	
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.	The Facility did not have a process in place to monitor and evaluate how records are used. Through interviews and review of documents, the Monitoring Team found indications that staff used the information in records as they were considering supports and services but also that materials were missing or misfiled, or were filed and posted too late to be used for decisions. Since the last tour the Facility's record keeping practices improved significantly for records contained in binders. Documents were organized, accessible, and it was easy to locate relevant information. Still, clinical staff reported that records are cumbersome and that they cannot always find the information they need. Clinicians may not find documentation due to delays in filing. Clinical staff report that the PSP provides needed information. PSPs were accessible in the active record. However, they did not always clearly specify the services and supports to be provided and who was responsible. Services were found in various sections of the active record; there was no single place in which all supports and services to be provided to an individual were listed, including the PSP. For example, skill acquisition/ habilitation goals were separate from PBSP goals,	Noncompliance

#	Provision	Assessment of Status	Compliance
		which limit the holistic understanding of how these relate to each other. Medical information can be found in various sections of the active record; health data may not be in the same binder as physician orders, for example. This is especially true when there are numerous binders for an individual. A system of stickers had been developed to identify where physician orders, integrated progress notes, and observation notes are found. Subtabs were added to the Nursing section to make it easier to find needed information. Staff reported using the active record to find a variety of information. Staff review not only the PSP but also the integrated progress notes, health maintenance plans, Another system to provide information from the record is the share drive that allows sharing of assessments so they are available to all clinicians and the QMRP on an individual's PST. However, as reported in Provision V.1, assessments were frequently not entered timely and therefore could not routinely be used for planning supports and services. The Facility did not have a policy specific to use of the share drive except for the requirement in Policy CMGT-12.01 that requires that assessments be placed in the folder for the individual on the S: drive no later than five working days prior to the initial PST meeting and requires PST members to review all assessments. A check by the Monitoring Team and reports from people interviewed confirmed that assessments were not routinely completed and placed on the share drive timely according to policy and were not available to review in advance of the PSP meeting. The Facility did not have a process to monitor and confirm either that assessments were posted to the share drive timely or that PST members reviewed them.	

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

1. Continuing efforts should be made both by DADS and DSSLC to develop or revise policies necessary to implement this agreement.
2. The Facility needs to develop a process to ensure and monitor posting of assessments on the share drive and to assess whether PST members access and review the information.
3. The Facility should develop a process for random selection of records for audit.
4. The Facility should separate data from primary and inter-rater reliability audits.
5. As the audit process provides data to permit trending, the QA/QI Council should continue to review the data and should consider whether the data indicate a need for an improvement initiative or corrective action plan.
6. A procedure should be developed and implemented to track whether assessments are completed and placed on the share drive timely.
7. A procedure should be developed and implemented to track whether PST members review assessment on the share drive prior to PSP meetings.

List of Acronyms Used in This Report

Denton State Supported Living Center

March 28-April 1, 2011 Compliance Visit

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ACP	Acute Care Plan
AED	Anti-Epileptic Drug/Automated External Defibrillator
ADHD	Attention Deficit Disorder
ADL	Activity of Daily Living
ADR	Adverse Drug Reaction
AIMS	Abnormal Involuntary Movement Scale
ANA	American Nurses Association
A/N/E	Abuse/Neglect/Exploitation
AP	Alleged Perpetrator
APC	Admissions/Placement Coordinator
APL	Active Problem List
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
AT	Assistive Technology
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
CIR	Critical Incident Review
CLDP	Community Living Discharge Plan
CLO	Community Living Options
CLODR	Community Living Options Discussion Record
CLOIP	Community Living Options Information Process
CMP	Comprehensive Metabolic Profile
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
DUE	Drug Utilization Evaluation
EKG	Electrocardiogram
ER	Emergency Room
FA	Functional Analysis or Functional Assessment
FFAD	Face to Face Assessment/Debriefing document
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
HRO	Human Rights Officer
HST	Health Support Team
HT	Habilitation Therapies (Habilitation Services)
IBW	Ideal Body Weight
ICD	International Classification of Diseases
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IDT	Interdisciplinary Team
IMC	Incident Management Committee
IMRT	Incident Management Review Team
IOA	Interobserver agreement
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 Committee
PBSC	Positive Behavior Support Committee
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
PO	Per Oral (by mouth)
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
TED hose	Thrombo Embolic Deterrent hose
TIVA	Total Intravenous Dental Anesthesia
TSH	Thyroid Stimulating Hormone
UIR	Unusual Incident Review or Unusual Incident Report
URC	Unified Records Coordinator
VCF	Virtual Client Folder
VDB	Verbally Disruptive Behavior
VNS	Vagal Nerve Stimulator
VRE	Vancomycin-resistant enterococcus