United States v. State of Texas

Monitoring Team Report

Denton State Supported Living Center
September 19-23, 2011

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Introduction

Background

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

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

In order to conduct reviews of each of the areas of the Settlement Agreement 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.

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

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

Methodology

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

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

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review, while other requests were for documents to be available when the Monitors arrived. The Monitoring Team made additional requests for documents while on site. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the facility. In other instances, particularly when the facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures.

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

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

Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement, as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement. The report addresses each of the requirements regarding the Monitors' reports that the Settlement Agreement sets forth in Section III.I, and includes some additional components that the Monitoring Panel believes will facilitate understanding and assist the facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the Settlement Agreement. This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report;
c) **Summary of Monitor's Assessment:** Although not required by the 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:** A determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement, and detailed descriptions of the Facility's status with regard to particular components of the Settlement Agreement, including, for example, evidence of compliance or noncompliance, steps that have been taken by the facility to move toward compliance, obstacles that appear to be impeding the facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;
e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and
f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the Settlement Agreement. It is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement.

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 greatly appreciates all this assistance from staff throughout the Facility. The Monitoring Team was especially appreciative of the efforts of the Settlement Agreement Coordinator, Sheila Carpenter, and of Katie Thompson. They ensured the documents requested were available before, during, and after the visit. They coordinated arrangements for all the meetings and observations.

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 the Facility 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.

Given the number of issues identified during the baseline review, it was expected that the change processes would take time. During this review, it was clear that the staff at the Facility had taken a number of steps to address identified issues and to comply with the Settlement Agreement. In a number of areas, progress had been made. In other areas, the foundation had been laid for change. In some areas, concerted efforts need to be made over the next six months to make the necessary improvements.

Population of the Facility at the beginning of the compliance visit was 518 individuals.

General Comments

DSSLC had made considerable progress toward compliance in several sections of the Settlement Agreement but less in others. It was clear to the Monitoring Team that the Facility was continuing to make efforts to improve services and supports.

The self-assessment provided by the Facility, for the most part, simply reported on actions taken, rather than evaluating whether the actions taken are producing the desired outcomes, and why or why not. It did not provide details as to the Facility's self-assessment processes, but rather listed some actions the Facility had taken since the last visit and, in some cases, provided a list of Action Steps and completion status. The Facility should consider how it might use its internal quality

assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes.

Restraints

Although the Monitoring Team did not find any provisions in compliance, much progress was noted. The Facility needs to address the use of medical restraint and had already begun to address this issue.

- Positive Practices and Improvements Made
  - Several individuals who had experienced crisis intervention restraint with some degree of regularity had been restraint free for two or more months. This suggests the Facility had taken proactive steps to improve the design and implementation of Positive Behavior Support Plans (PBSPs) and other measures to provide effective supports.
  - The Facility provided a considerable amount of Facility specific restraint training to QMRPs, nursing staff, and direct care professionals (DCPs) since the last review. Improved practices, and documentation, that resulted from this training was apparent to the Monitoring Team.
  - The Restraint Reduction Committee meets monthly. In reviewing minutes, and through observation of the meeting held during the review, it is evident the committee engages in substantive review, problem solving, and the development of specific recommendations.
  - No evidence of use of prone restraint was identified.
- Improvements Needed
  - The primary obstacle to achieving compliance with Section C of the SA is deficient practices and documentation associated with medical restraint. A similar observation was made in the last review and little progress was apparent during this review. Very recent changes hold promise for improvement in pre-treatment sedation, and the Facility had recently allocated staff positions specifically to work on programs to reduce the need for medical restraint.

Abuse, Neglect and Incident Management

Two provisions and several components of other provisions were found in substantial compliance. The Facility has continued to improve its processes to minimize and address abuse and neglect, and to identify from incidents information to review to ensure reporting is accurate and to minimize incidents.

- Positive Practices and Improvements Made
  - DSSLC had a well-organized system for abuse prevention, detection, and reporting, and a well-organized and managed system for incident management.
  - The knowledge of Direct Care Professionals with respect to abuse and neglect was much improved from that observed at the previous review.
  - Nothing discovered in the course of this review suggested anything but a zero tolerance policy towards abuse and neglect, or, any instances of failure to report suspected abuse or neglect.

- In every instance where an alleged perpetrator (AP) was known the AP was immediately placed in no contact status and adequate additional action was taken to protect individuals in each case.
- The Facility had a regular audit process in place capable of detecting instances of unreported injuries.

- Improvements Needed
  - 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 continue 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 also over time, as occurs with some other data elements in the report.
  - All allegations of physical abuse should be referred to law enforcement as any substantiated allegation could represent some form of assault; two investigations did not include documentation that a law enforcement referral had occurred.

Quality Assurance

The Facility continued to make progress in the development of a QA process that can measure ongoing compliance with the requirements of the SA.

- Positive Practices and Improvements Made
  - A comprehensive Quality Assurance Plan had been formalized noting for each section of the SA the monitoring tools in use, the frequency of monitoring, and responsibilities of various staff who must implement the plan.
  - Compliance reports were routinely prepared and presented to the QA/QI Council for review and discussion. The amount of substantive discussion at the QA/QI Council was much improved compared to that observed at the last review.
  - The Facility had begun a more formal process for inter-rater reliability from that observed at the last review.
- Improvements Needed
  - At the time of the review, the QA activity in place at DSSLC consisted largely of administrative steps directed at development of specific actions necessary to correct specific problems discovered through monitoring and auditing conducted by residential units and facility departments, and by Program Auditors in the QA Department. Although this is a necessary component of Quality Assurance, there is also a need to develop a broader strategic action plans to correct systemic problems identified through the analysis of data collected over time from a variety of sources, such as: the results of monitoring/auditing referenced above; tracking and trending data described in E1; regulatory reports (CMS 2567's); reports (anecdotal and written) coming from DADS subject matter experts, outside consultants, DFPS, OIG, and others; and, data collected from self-advocacy group meetings, family member meetings, and other stakeholders.

Integrated Protections, Services, Treatments and Supports

Staff had been trained in the new PSP process, and it was clear that the Facility was using the new process in planning meetings. A group of four staff had been assigned to facilitate PSP planning meetings and mentor the QDDPs. The Monitoring Team commends the Facility for continuing to seek ways to enhance the PSP process. Nevertheless, the PSP process continues to need improvement. Although there is much more interdisciplinary discussion at meetings, it is still not evident that services, supports, and treatments are planned in an integrated manner.

- Positive Practices and Improvements Made
  - Additional training and coaching had been provided to QMRPs/QDDPs on the PSP process and on skills in facilitation.
  - The Facility was trying a pilot process for completing the Personal Focus Assessment as a Personal Focus Interview.
  - The Workgroups for Sections F, T and U had also been merged in recognition of their common key focus of person-centered PSP development.
- Improvements Needed
  - PST members sometimes came to planning meetings without a basic knowledge or awareness of an individual's current status or needs.
  - PSTs often failed to conduct comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs.
  - PSPs did not consistently specify 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 and meet identified needs, nor did barriers to living in the most integrated setting always lead to goals, objectives, or service strategies.
  - PSP strategies did not reflect encouragement of community participation in any meaningful or purposeful manner; however, the Active Treatment Department had begun to attempt to create meaning and purpose for community integration activities by correlating community outings with other objectives for specific individuals, and providing varying level of instructions for staff as to training to be implemented during the activities.

<u>Integrated Clinical Services</u>

The Monitoring Team found continuing progress toward compliance, although neither provision was yet in compliance.

- Positive Practices and Improvements Made
  - The Facility involved more disciplines in systemic reviews, such as infirmary rounds, morning medical meetings, and committees such as the pneumonia workgroup.
- Improvements Needed
  - PSP attendance by clinicians had improved, but there was still need for additional participation.
  - Facility clinicians documented review of most, but not all, consultations by non-Facility clinicians.

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

There is a need for better definition of clinical pathways and better tracking of timeliness and quality of assessments.

- Positive Practices and Improvements Made
  - Diagnoses generally were consistent with the ICD or DSM classifications.
- Improvements Needed
  - Adequacy of assessments and evaluations remained problematic at this visit. Throughout this report, there are examples in which assessments were not routinely completed on a timely basis. When assessments were completed, the PSTs did not consistently use the available results appropriately to develop, implement, and revise the PSP as necessary.
  - Assessment and treatment of chronic conditions should be more aggressive and comprehensive. The Facility had begun to monitor treatment of chronic health conditions.
  - There is not routine use of clinical indicators to monitor health status of individuals or in aggregate to demonstrate efficacy of clinical practice at the Facility.

<u>At-Risk Individuals</u>

The process for rating and addressing risk continues to need improvement. PSTs are still learning how to assess risk and how to use the assessment of risk in planning supports and services. There is a need for additional training and oversight to achieve greater consistency.

- Positive Practices and Improvements Made
  - The risk assessment process had been integrated into the PSP planning process.
- Improvements Needed
  - Risk assessments were not always conducted within five working days of risk identification or a change in circumstances
  - Interdisciplinary discussion required to properly assess risk and develop risk mitigation strategies was not always apparent to the Monitoring Team.
  - Assessments were not sufficiently comprehensive to enable interdisciplinary discussion.
  - Risk guidelines provided to QDDPs 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.

<u>Psychiatric Care and Services</u>

Psychiatry services continued to improve. Several provisions were found in compliance. Work processes continue to need to evolve toward greater integration with other disciplines.

- Positive Practices and Improvements Made
  - A process was in place for individuals to receive clinically justifiable evaluations and diagnoses by board certified or board eligible psychiatrists.
  - Reiss screens were administered to all individuals who required them.

- The Psychoactive Medication Oversight Committee was providing effective clinical oversight in the area of polypharmacy, and data for the past two years continued to show a gradual and sustained decrease in the amount of interclass and intraclass polypharmacy.
- Medication Treatment Plans had improved and now included clear rationales for the proposed treatments.
- Staff psychiatrists attended neurology clinics, and a process for review and oversight of medications prescribed by both neurology and psychiatry were in place.

- Improvements Needed
  - Medication plans need to link medication treatment plans to symptoms or behavioral characteristics of identified psychiatric disorders, and the tracking of data that will help determine whether the medication is effective.
  - The Facility had added staff to assist the process for the development of desensitization plans for identified individuals, but that process remains at a very early stage.
  - The Facility used Appendix B evaluations for new admissions, annual reviews, and consultations. However, additional focus was needed to assure that documentation was adequate to fully substantiate psychiatric diagnoses in terms of all the symptoms required to fulfill DSM IV or DMID diagnostic criteria.
  - In several cases the Monitoring Team found that relevant behavioral information had not been included in the PSP. A recent revision of the PBSP and work processes around that document has helped provide more integration between the behavioral healthcare disciplines, but the new format had just been implemented.

<u>Psychological services</u>

Staff, documentation, and achievements by individuals living at the Facility reflected the diligence and determination of the Facility to achieve compliance in relation to Provision K. The Facility had demonstrated continuing improvement in staffing, data, functional assessment, and other areas. Although the Facility had demonstrated effort to improve the quality of services, and in many circumstances demonstrated considerable progress, a sizable amount of work remained before substantial compliance could be achieved.

- Positive Practices and Improvements Made
  - Both an internal and external peer review process were in place. Furthermore, the evidence reflected that.the peer review process was capable of producing improvement in the PBSPs and behavior assessments.
  - The number of Board Certified Behavior Analysts employed by DSSLC had increased, and the percentage of the staff enrolled in BCBA coursework remained high.
  - Efforts to collect treatment data had substantially improved in comparison with the baseline site visit. Data for both target and replacement behaviors were included in the data collection process.
  - The Facility had continued to expand the number and location of interobserver agreement observations.
- Improvements Needed
  - Although the functional assessments completed by the Facility were approaching the level of substantial compliance., at least two important areas regarding functional assessment continued, however, to reflect substantial

limitations. The assessment process did not integrate the assessment of mental illness into the functional assessment. Although substantial documentation of the assessment and treatment by the psychiatrist was often included, this information served only to document a parallel process rather than a process that contributed to the functional assessment. Additionally, the functional assessments reviewed did not clearly identify replacement behaviors that served the same function as the behavior targeted for reduction.

- The Facility had also greatly expanded the efforts to provide interventions other than behavior analytic programs to people living at DSSLC.. In many of the interventions reviewed; however, there was a lack of evidence-based approaches in the intervention process.

Medical Care

Medical staff at the Facility continued to make efforts to improve. However, there remain examples in which follow up on medical conditions must be improved. Medical services need to be more integrated into the PST and the PSP process.

- Positive Practices and Improvements Made
  - The Facility has made significant improvements with physician documentation practice and on follow-up on acute conditions, and has implemented a good internal review process. and participated in the DADS Medical Provider QA Audits. A QA physician also reviews for outstanding clinical issues, such as assessing the management of acute care, and efficacy of the treatment for chronic conditions.
  - The Monitoring Team identified substantial improvements in the area of mortality review process.
- Improvements Needed
  - The Facility must better address the management of acute and chronic care conditions and seek understanding of the underlying etiology of medical conditions.
  - Medical Services must become fully integrated in the team process.
  - The Facility has yet to implement a mechanism to assess and ensure physician's clinical competency.
  - The Facility did not have a process in place to identify clinical indicators and did not conduct data analysis for medical QA purposes.

Nursing Care

The Nursing Department continued to demonstrate a high degree of enthusiasm and commitment to moving toward compliance with all provisions of the Settlement Agreement.

- Positive Practices and Improvements Made
  - A new Infection Control Preventionist was hired to manage the Infection Control Program. This nurse had made significant improvements in the Infection Control Program since being hired.
  - There was consistent use of the SOAP format for documentation. The P (plan), with rare exception, indicated what would be followed-up on as opposed to simply stating "will continue to monitor" as was noted in past compliance reviews.

- Changes in individuals' health status were better recognized and assessments completed with prompt notification of findings reported to the providers (physicians and nurse practitioners).
- The Facility's Emergency Response System had made significant improvements. Mock Medical Emergency Drills were more consistently conducted; the drill data were being tracked, analyzed, and trended. An Emergency Response Committee was fully operational and was reviewing the data from the drills and other emergency response issues and making corrective action plans when indicated.
- All core State and Facility nursing policies, procedures, and processes, had been finalized. The Nurse Educators maintained an excellent tracking database and were able to validate that 97% to 100% of the nursing staff had been trained in the core policies, procedures, and processes.
- The Facility had developed and implemented a comprehensive Medication Error Database to track, analyze and trend medication errors using a root cause analysis approach. The medication error data were being utilized to identify areas of practice for which corrective action plans were needed to reduce the incidents of medication errors.

- Improvements Needed
  - Although great strides had been made to improve the quality of the nursing assessments, the nursing summaries need continued improvement to critically analyze clinical data derived from the assessments, for each identified nursing problem/diagnosis, to accurately reflect whether individuals' health status was improving, maintaining, or regressing.
  - The Nursing Department needs to continue to individualize health care plans, collaborate with other relevant disciplines in developing plans, and ensure the plans include the frequency of interventions/actions to be carried out, by whom, when and where to document interventions/actions carried out. The effectiveness of the plans need to be evaluated when the goals/objectives are not met to prevent or minimized the identified problems.

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

Pharmacy Services demonstrated significant improvement in a number of areas. New procedures had been implemented for metabolic screening and addressing adverse drug reactions. Recent hiring of an additional pharmacist should allow the Facility to make additional improvement before the next compliance visit.

- Positive Practices and Improvements Made
  - The Facility's process for monitoring new medications was sound and met expectations of the Settlement Agreement.
  - The Facility has a comprehensive policy for conducting DUEs, and had provided meaningful DUEs during the past six Months. All new medication orders are evaluated though a DUE process.
- Improvements Needed

- The Quarterly Drug Regimen Review (QDRR) process at the Facility did not meet standard of care practice. It is essential that the Facility develop a process that ensures each QDRR is completed per standard of care practice, and that there is a mechanism to perform Quality Assurance outcomes for the QDRR process.
- The Facility developed an excellent Metabolic Screening Policy, developed an excellent review process for benzodiazepines, thoroughly reviewed intra-class polypharmacy, and had an excellent process to assess chemical restraints; however, there was no mechanism in place to address anticholinergics, the new Metabolic Screening Policy was not yet implemented, a mechanism to address STAT medications had not been developed and implemented, and polypharmacy was not fully addressed.
- Tardive dyskinesia and side effects monitoring using DISCUS and MOSES was in place, but tardive dyskinesia (TD) was not assessed more frequently when clinically indicated. DISCUS and MOSES assessments for the most part indicated no side effects given the polypharmacy use at the Facility, one would expect more adverse findings following an assessment.
- The Medication Variance process was not well integrated among nursing, pharmacy and physician services.

<u>Physical and Nutritional Management</u>

Although the Facility was taking action to improve physical and nutritional management, physical and nutritional management plans (PNMPs) were not comprehensive, nor were they implemented accurately. There was no process to ensure people at increased level of risk received supports from trained staff or increased monitoring. While some improvement have been noted, primarily with the PNMT as well as the addition of a PNM nurse, DSSLC continued to fall short of making the strides needed to make substantial improvement in mitigating the risk associated with physical and nutritional supports.

- Positive Practices and Improvements Made
  - 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.
- Improvements Needed
  - A process that outlines the responsibilities of the PNMT and PNMC as well as their scope was developed but had not been finalized and implemented as of this review. There was still no evidence that data were collected and the team was reviewing this data to better identify system issues or respond to recurrent issues on a regular basis
  - A new risk process that is intended to more accurately identify individuals at risk had been developed and implemented; however, lack of use of clinical judgment and critical thinking when the PSTs had to move beyond the guidelines often resulted in inaccurate assignment of risk.
  - Individuals were not provided with comprehensive assessments in response to changes in status or as part of an annual assessment due to often referring to outdated tests and external assessments.
  - Supports regarding the areas of oral care, head of bed assessment, bathing positioning, and medication administration were missing from the assessment process and were not comprehensively included in the PNMP.

- PNMPs were not comprehensive due to the plans lacking information regarding oral care and medication administration strategies.
- Staff was observed not implementing PNMPs and displaying safe practices that minimize the risk of PNM decline.
- There was no process in place to ensure PNM supports for individuals who are determined to be at an increased level of risk were only provided by staff who have received the competency based training specific to the individual.
- DSSLC revised the monitoring form so that it would cover all aspects in which the individual was determined to be at increased risk; however, there was not a formal monitoring process in place nor was monitoring being implemented in all homes.
- An Aspiration Pneumonia/enteral Nutrition evaluation was developed which was a positive step. The issue was that the evaluation was completed as more of a review and did not investigate root cause.

Physical and Occupational Therapy

There had not been significant improvement in Physical and Occupational Therapy (PT and OT) services; the focus had been on implementation of PNM supports. Filling of an opening for one OT and one PT would establish ratios that would be adequate to address OT/PT practices in addition to the increased demand of PNM supports.

- Positive Practices and Improvements Made
  - Assessments that indicated whether or not the individual required OT/PT supports and services.were completed in accordance to the schedule set forth by DSSLC.
  - DSSLC was in the process of looking at bathing systems (shower chairs, trolleys and submersible tubs) in an effort to expand options for individuals who require more intensive interventions during this activity.
  - Assessments/screenings were completed within 30 days of admission for those individuals who were newly admitted.
- Improvements Needed
  - Assessments were not being consistently completed in response to a change in status nor were they comprehensive as they lacked objective measurements and detailed information that allowed for comparative annual analysis.
  - Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills.
  - Plans were not implemented as written.
  - 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.
  - There was a lack of problem solving and identification of issues that contributed to decline.

Dental Services

There was an abundance of dental services including a process to improve oral hygiene at the living area. However, the Facility was unable to report which individuals were up to date on services. Dental Services needs to be better integrated into the PSP process.

- Positive Practices and Improvements Made
  - There was an abundance of new policies and procedures for the delivery of dental services.
  - The Monitoring Team was impressed with the process developed and recent outcome of improving oral hygiene at the living area.
  - The Facility was noted to have an operational process to provide emergency dental services.
- Improvements Needed
  - The Facility was unable to report which individuals were actually up to date with their dental health care needs and who remains deficient and for what reason they were deficient, and therefore could not assure that individuals are receiving adequate and timely dental services.
  - Dental Services was not well integrated in the Team process.
  - The Facility had made little headway with developing a dental desensitization program.

<u>Communication</u>

Due to the lack of staff availability, progress in these areas continued to shown very slow improvement. Implementation of devices and mentoring of staff related to these devices were not occurring with enough frequency to improve the overall level of care as it related to communication expansion.

- Improvements Needed
  - DSSLC only had 3.5 SLPs on campus. The ratio of therapist to client was 1:172, which was too large a caseload for the therapists to actively participate in all facets of care.
  - Individuals identified as having decreased communication had not consistently been provided with the needed assessments, and assessments that were provided were not consistently comprehensive in identifying methods to expand communicative functioning.
  - Programs in place to assist some individuals were not being consistently implemented.
  - 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 and there was not a process in place that ensured devices were meaningful or functional.

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

Although no substantial compliance was noted, the Facility had achieved progress in some areas. Despite these areas of improvement, however, the site visit also encountered several areas in which supports and training were not adequate.

- Positive Practices and Improvements Made
  - Many of the skill acquisition programs were based upon some form of task analysis.

- Training involved ample opportunities for the target behavior to occur, thereby ensuring that reinforcement and learning could occur.
- Skill acquisition programs also often included specific reinforcement for successful responses.
- The Facility had provided several training classes to employees regarding the development and implementation of skill acquisition programs.
- Although the number of outings reversed slightly with the onset of Summer, the number of monthly community outings remained substantially greater than earlier in the year.

- Improvements Needed
  - Training programs often lacked the detail and specificity necessary for staff to conduct skill acquisition training consistently and competently.
  - Skill acquisition programs often required individuals to demonstrate mastery for unnecessarily long durations before the training method was revised.
  - There were substantial lapses in the provision of active treatment and failure to intervene in order to ensure the safety of individuals living at the Facility.

Most Integrated Setting

The Facility had undertaken initiatives to train staff, enhance the PSP process to better identify preferences for community living, to ensure that professional staff make recommendations regarding the most integrated setting and to provide effective facilitators in the development of the plans. Nevertheless, much improvement is needed in encouraging and planning for more living in a more integrated setting. Post Move Monitoring (PMM) verified that identified supports were in place. Four individuals had moved in the past six months.

- Positive Practices and Improvements Made
  - The Facility developed an annual report on obstacles to community transition and issued a Community Placement Report.
  - The Facility was to be commended for undertaking several initiatives to enhance the PSP process to better identify preferences for community living, to ensure that professional staff make recommendations regarding the most integrated setting and to provide effective facilitators in the development of the plans.
  - PMM Checklists were being completed in a timely manner. The Post-Move Monitor did, at each visit, observe each site at which the individual lived, worked, or participated in day activity services. The Post-Move Monitor verified that each support was in place and being implemented.
  - The Facility policy regarding alternate placements was consistent with DADS policy as well as with CMS discharge requirements. Two alternate discharges to other SSLCs occurred during the last six months and appeared to have been completed within the requirements of the policy.
  - An additional position had been added to the staffing within the Department of CFR to assist with the CLDP and transition processes in anticipation of a growing number of community referrals and placements.

- Improvements Needed
    - Less than 1% of the population transitioned to the community in the past six months, a pace well below that of most other SSLCs.
    - Many of the planning processes continued to be hampered by a failure of the Facility to ensure the completion of adequate and timely assessments.

Consent

A statewide policy draft on Guardianship had been promulgated; the policy is in process of revision. Activities in the area of guardianship education had been implemented.

- Positive Practices and Improvements Made
    - There was still no standardized approach in use to assessing and determining the actual need for an LAR on an individualized basis that was consistent with currently accepted professional standards of practice, but the Facility had received permission from DADS to pilot the use of a tool found from another state.
    - DSSLC reported a number of activities in the area of guardianship education during the past six months.
    - One of the most significant undertakings in this area had been the recent development and orientation of the Guardianship Committee.
- Improvements Needed
    - The Facility did not have an appropriate methodology in place to determine the need for guardianship.

Recordkeeping and General Plan Implementation

The Facility maintained a unified record for each individual. The unified record at DSSLC consisted of an Active Record, Master Record, and an Individual Notebook. Recordkeeping was improved from the last compliance visit. The Active Records were more generally complete and legible. Nevertheless, continued improvement is needed. No Active Records met all requirements of Appendix D, although they continue to improve. Although no provision of this Section was in compliance, progress continued, and provisions are approaching compliance.

- Positive Practices and Improvements Made
    - The process to audit records was nearing compliance. There was now a process to select records randomly for audit. Corrective actions for individual records were routinely identified, and the URC checked each record to ensure corrections were completed.
- Improvements Needed
    - The Facility needs also to ensure that records are secure and can only be accessed by people who are authorized to view them.
    - There were examples of actions taken to correct systemic issues identified through records audits, but there was no process in place to review the effect of those actions.

- The Facility had initiated processes to monitor and evaluate how records are being used. Nevertheless, there were examples in which information in the record should have led to actions, but there was not an indication that this information was used to make decisions.

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. DSSLC Plan of Improvement (POI) 9/7/11 2. DADS Policy 001: Use of Restraint, 8/31/09 3. Settlement Agreement (SA) Section C Presentation Book (undated) 4. DSSLC Policy CMGMT-20 Limitation of Restraint as a Crisis Intervention 9/7/11 5. DSSLC Policy CMGMT-21 Dental/Medical Sedation and Restraint 8/5/11 6. DSSLC Dental Services policy DS-15: Need for Dental Desensitization 8/1/11 7. PMAB Training Curriculum (undated) 8. Training Curriculum for RES0105 (Restraint: Prevention and Rules for Use at MR Facilities) and RES0110 (Applying Restraint Devices) undated 9. Facility-developed restraint training curriculum: Fundamental Aspects of Restraint (undated) 10. Sample of staff training records (Sample C.2) 11. Restraint log of crisis intervention restraints 4/1/11 to 8/15/11 12. Restraint log for medical restraint 4/1/11 to 8/15/11 13. Restraint log for chemical restraint 4/1/11 to 8/15/11 14. Restrain log for dental IV sedation 4/1/11 to 9/7/11 15. Restraint documentation files for sample (Sample C.1) 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 #580, #50 (4/18), #250 (5/4), #60 (5/10), #306 (6/15 at 1:03pm), #624 (5/18, 6/19 at 6:25am, 6/22 at 10:18pm, 8/4 at 8:56pm), #537 (8:41am), and #217 (4/17 and 7/30) 16. Restraint documentation files for two crisis intervention chemical 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 #306 and #624 17. Restraint documentation files for sample (Sample C.3) of pretreatment sedation medical restraint for medical procedures for Individuals #170, #425 (4/13), #488 (5/24), #507, #554, #240 (7/25), #656, #472, #435, #601 (4/12), #570, #199, #167, #545, #210, #624, #395, #247, #722, #590, #612, and #526 18. Restraint files for sample of Individuals undergoing dental IV sedation for Individuals #15, #21, #35, #165, #181, #199, #493, #537, #639, and #740 19. Documentation for individuals who were restrained more than 3 times in a rolling 30-day period for Individuals #50, #127, #217, #336, #337, #381, and #624 including PSPs, PSP addenda, PBSPs, PBSP progress notes, and restraint documentation. 20. List of Restraint Monitors 8/5/11

	21. Clinical Justification and related information for extraordinary circumstances for SPCI for Individuals #336, #337 and #381 22. Staff injuries during restraint 4/1/11 to 8/15/11 23. List of individuals injured while under restraint 4/1/11 to 8/15/11 24. List of individuals with a Safety Plan for Crisis Intervention (SPCI) 8/4/11 25. List of Individuals with a desensitization plan and sample plans 26. Restraint Trend Analysis report for July, 2011 27. Restraint Reduction Committee minutes 4/29/11, 5/31/11, 6/27/11, and 8/1/11 28. Incident Management Review Team (IMRT) Meeting minutes for 6/22/11, 6/29/11, 7/6/11, 7/13/11, 7/20/11, 7/27/11, 8/3/11, 8/10/11, 8/17/11, 8/24/11, and 8/31/11 29. DADS Report MHMR0102 Percent of All Employees Completing Courses of Training Program 9/1/11 **People Interviewed:** 1. Jill Wooten, BCBA 2. Nancy Condon, Facility Director 3. Randy Spence, Director of Behavioral Services 4. Lori Powell, Director of Quality Assurance 5. Ken Horstman, Director of Residential Services 6. Five Direct Care Professionals (DCPs) **Meetings Attended/Observations:** 1. Incident Management Team (IMRT) 9/19/11 2. Restraint Reduction Committee 9/22/11 3. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 9/20/11 4. Restraint Review Meeting for Individuals #337 and #381 9/22/11 5. Risk meeting for Individual #306 9/20/11 6. Group meeting with Monitoring Team and DSSLC Facility Director and senior staff re: medical restraint 9/23/11
	Facility Self-Assessment: The DSSLC's Plan of Improvement (POI) reported that Provision C.2 and C.6 were in substantial compliance with the Settlement Agreement (SA). 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. The Facility used data from its SA monitoring tools as a measure to determine its self-assessment ratings. When the Monitoring Team did not agree with the Facility self-assessment it was largely due to the Monitoring Team applying stricter standards in achieving compliance; for example, in C.8 the Monitoring Team does not believe the process for review of restraint had a sufficient clinical orientation. The primary obstacle to achieving compliance with Section C of the SA is deficient practices and documentation associated with medical restraint. A similar observation was made in the last review and little progress was apparent during this review. For other restraint, policy's, procedure, and documentation systems are in place and for the most part require only minor changes and continued

	vigilance through the Facility's monitoring process to achieve compliance.
	Summary of Monitor's Assessment: The DSSLC's Plan of Improvement (POI) reported that Provision C.2 and C.6 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. DSSLC's policies that govern restraint appear sufficient, if consistently applied, to achieve compliance with the SA. The policy on medical restraint was revised since the last review. In addition to procedure changes medical restraint has been included in the Facility's monthly trend report. No evidence of use of prone restraint was identified. Several individuals who had experienced crisis intervention restraint with some degree of regularity had been restraint free for two or more months. This suggests the Facility had taken proactive steps to improve the design and implementation of Positive Behavior Support Plans (PBSPs) and other measures to provide effective supports for these individuals. The use of medical restraint had increased. The July Trend Analysis reported a monthly average of 36 oral pretreatment restraints in the four month period April through July, 2011. The monthly average for the prior four months was 28. This was a 29% increase. The July Trend Analysis reported a monthly average of 18 IV sedation medical restraints in the four month period April through July, 2011. The monthly average for the prior four months was 13. This was a 39% increase. The primary obstacle to achieving compliance with Section C of the SA is deficient practices and documentation associated with medical restraint. A similar observation was made in the last review and little progress was apparent during this review. Very recent changes hold promise for improvement in pre-treatment sedation, and the Facility had recently allocated staff positions specifically to work on programs to reduce the need for medical restraint. For other restraint, policies, procedure, and documentation systems were in place and for the most part require only minor revisions and continued vigilance through the Facility's monitoring process to achieve compliance. The Facility's use of the SA monitoring tools was providing data to identify practice and documentation discrepancies requiring administrative follow-up. The Facility provided a considerable amount of Facility specific restraint training to QMRPs, nursing staff, and direct care professionals (DCPs) since the last review. Improved practices, and documentation, that resulted from this training was apparent to the Monitoring Team. The knowledge of Direct Care Professionals in restraint policy and application was significantly improved from that noted at the last review.

	Documentation associated with restraint use, except medical restraint, was much improved from that noted at the last review. The Restraint Reduction Committee meets monthly. In reviewing minutes, and through observation of the meeting held during the review, it is evident the committee engages in substantive review, problem solving, and the development of specific recommendations.

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C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	In its Plan of Improvement (POI) the DSSLC reported that it had not yet achieved substantial compliance with this provision of the Settlement Agreement (SA). The Facility's Settlement Agreement (SA) monitoring system reported recent compliance rates of 71% and 78% leading the Facility to conclude it is not yet in substantial compliance. The Monitoring Team concurs with the Facility's self-assessment. DSSLC Policy CMGMT-20 Limitation of Restraint as a Crisis Intervention (11/5/09) and DSSLC Policy CMGT-21 Dental/Medical Sedation and Restraint policy (8/5/11) guide facility practices with respect to restraint use. The Dental/Medical Sedation and Restraint policy had been revised since the last review to more clearly describe policy and procedural expectations. DSSLC Limitation of Restraint as a Crisis Intervention policy (CMGMT-20) is comprehensive and is directed at the practices necessary to achieve compliance with the Settlement Agreement. From interviews and review of documentation most staff at the Facility understood the expected practices called for in this policy and efforts to comply with the policy were apparent. Additionally, the Facility conducted routine auditing of restraint documentation, using standardized monitoring tools, which provided the necessary data to identify practice and documentation discrepancies requiring administrative follow-up. The data resulting from this monitoring was also used by the Facility to determine its self-assessment rating. The DSSLC had three individuals (Individuals #336, #337, and #381) who were frequently restrained, each of whom has special circumstances associated with their treatment plans. For other individuals living at the DSSLC, the frequency of use of restraint had remained steady. The Facility averaged 16 crisis intervention restraints per month in the four-month period April through July, 2011. The Facility averaged 15 crisis intervention restraints per month during the prior four months, December, 2010 through March, 2011. The use of medical restraint had increased. The July Trend Analysis reported a monthly	Noncompliance

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		average of 36 oral pretreatment restraints in the four-month period April through July, 2011. The monthly average for the prior four months was 28. This was a 29% increase. The July Trend Analysis reported a monthly average of 18 IV sedation medical restraints in the four month period April through July, 2011. The monthly average for the prior four months was 13. This was a 39% increase. Several individuals who had experienced crisis intervention restraint with some degree of regularity had been restraint free for two or more months. This suggests the Facility had taken proactive steps to improve the design and implementation of Positive Behavior Support Plans (PBSPs) and other measures to provide effective supports. Individuals #110 and #306 had been restraint free for two months, Individual #60 for three months, Individual #127 for five months, and Individual #411 for nine months. The Facility is to be commended for these outstanding results. DSSLC Dental/Medical Sedation and Restraint Policy (CMGMT-21) is directed 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, did not, or if they did they did not consistently use the procedures in the policy correctly. For example, this policy clearly lays out the requirements for monitoring both physical and mechanical restraint used for medical purposes and pre-treatment sedation; nevertheless, as noted in examples below, not all documentation related to use of pre-treatment sedation was completed. DSSLC Dental Services policy DS-15: Need for Dental Desensitization, implemented 8/1/11, requires that dental staff document each individual's behavior to determine if a person is "compliant" (no desensitization needed), "moderately compliant" (with a recommended action of visiting the dental clinic when not scheduled for dental work, and/or having the Personal Support Team develop informal or formal desensitization training), or "fully non-compliant" (with a recommended action of asking behavioral services intervention for a formal desensitization plan). One of the medical restraints in the sample was after 8/1/11 (Individual #210) and there was no evidence presented to the Monitoring Team to indicate this expected procedure occurred. Some nursing staff received additional training in August, 2011 on nursing responsibilities related to restraints. Twenty-seven nurses attended this training. The Facility also initiated an "Order Form for Medical/Dental Sedation Restraint" and an "Outpatient Medical Consultation/Procedure Form." Both were intended to provide more guidance to nursing staff in the procedural requirements associated with medical restraint. Both went into effect in August. The sample of medical restraints consisted largely of restraints prior to the implementation of these new procedures. The Monitoring Team is hopeful that in its next review the effect of these new procedures will	

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		be evident. A sample of crisis intervention physical restraint episodes, referred to as Sample C.1, was selected. The source document used for the sample was the listing of restraints used since the last review. The sample included eight individuals and 12 restraint episodes, representing 20% of physical restraint episodes since the last review. 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 #580, #50 (4/18), #250 (5/4), #60 (5/10), #306 (6/15 at 1:03pm), #624 (5/18, 6/19 at 6:25am, 6/22 at 10:18pm, 8/4 at 8:56pm), #537 (8:41am), and #217 (4/17 and 7/30). Four of the individuals in the sample had Safety Plans for Crisis Intervention (SPCI) and four did not. A separate sample was selected for medical restraints. The Facility prepared a documentation file 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. Three individuals (#336, #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. The Facility had a Safety Plan for Crisis Intervention (SPCI) and a "Clinical Justification for Extraordinary Circumstances", approved by the Facility Director and attending physician, in place for each individual. <u>Prone Restraint</u> Based on Facility policy review, prone restraint is prohibited. Based on review of restraint records, restraint reduction committee minutes, interviews with Direct Care Professionals (DCPs), and minutes of the Incident Management Review Team (IMRT), no use of prone restraint was identified or the subject of any discussion in meeting minutes. The Facility had conducted additional training of DCPs since the last review which resulted in improved staff knowledge of restraint policy and practices, including the prohibition of use of prone restraint. This training was titled "Fundamental Aspects of Restraint" and was developed by the DSSLC Behavior Services Department. It is competency-based and directed at the specific practices expected at the DSSLC.	

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		Other Restraint Requirements State and Facility policy states 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. Crisis intervention physical restraint records were reviewed for Sample C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. Restraint documentation was noticeably improved since the last review. The Facility monitoring process determined a high level of compliance with this requirement for several months, followed by two months where compliance rates dropped to 71% and 78%. The following are the results of the review by the Monitoring Team from the restraint sample: In 11 of 12 records in the sample (92%), there was documentation showing that the individual posed an immediate and serious threat to self or others. For Individual #537 the language on the Restraint Checklist suggests restraint use may have been necessary as a result of the Individual refusing to give the telephone back to staff. In 11 of 12 records in the sample (92%), a review of the descriptions of the events leading to behavior that resulted in restraint 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 Face-to-Face Assessment/Debriefing (FFAD) document. This was not the case for the restraint of Individual #217 (4/17/11). The appropriate section of the FFAD was not completed. Other than determining if the correct box was checked on an FFAD (or drawing conclusions from certain data on a Restraint Checklist) it is not possible to determine if restraint was or was not used for the convenience of staff or 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 K the DSSLC has made continued improvements in its overall approach to behavioral programming that move it in the direction of SA compliance. These continued improvements, along with the data presented earlier, lead the Monitoring Team to believe it is likely that restraint use is used in a clinically justifiable manner and not for the convenience of staff. Additionally, the Monitoring Tools used by the DSSLC to	

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		measure compliance with this part of the Settlement Agreement (SA) show consistently high compliance. In eight of 12 restraint records (67%), 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. Individuals #50, #60, and #624 had an SPCI. The Restraint Checklist for four restraints involving these three Individuals did not include "Interventions in Safety Plans" within the section of the Restraint Checklist requiring that all "Interventions Attempted to Avoid Restraint" be checked. In each case multiple interventions (verbal prompt, redirection, PMAB protections skills, changed environment, traded out staff, etc.) were checked; however, it was not clear if these actions included all actions described in each individual's SPCI. Other than this relatively minor documentation disparity all Restraint Checklists included sufficient information regarding whether a graduated range of less restrictive measures was used, checking multiple types of interventions and adding narrative descriptors on the Restraint Checklist. The DSSLC had conducted additional training of DCPs and Restraint Monitors since the last review. It was apparent to the Monitoring Team that this training, and Behavior Services department monitoring, had significantly improved crisis intervention restraint documentation. The Monitoring Team reviewed five cases of IV sedation, for Individuals #21 (06/22/11) #35 (04/20/11), #493 (05/11/11), #537 (04/06/11), and #639 (05/18/11). In each case the Pre-Post –Sedation checklist was used, although for individual #537 the second page of the checklist that contained vital signs measurements was not received. In all five cases, the Monitoring Team found documentation of a single REACT score of 8 or higher, although the protocol called for two scores before the Individual is allowed to return home. Vital signs were obtained prior to the procedure except for one individual who declined. In each of the five cases there was follow-up from a nurse on the home unit documenting adequate recovery at home. The Monitoring Team reviewed five cases of oral sedation for medical procedures, for Individuals #170 (for a dental procedure on 07/12/11), #425 (for a mammogram on 04/13/11), #554 (for a dental procedure on 06/07/11), #656 (for a mammogram on 06/16/11), and #435 (for a dexa scan and mammogram on 04/07/11). Pre-Post-Sedation checklists were used in all cases. The required two REACT scores of 8 or higher (or baseline) were not located for any of the individuals, and physician orders for the sedation were not located for Individual #425. Two individuals were the subject of emergency chemical restraint since the last review.	

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		Individual #624 was chemically restrained on 7/5/11 as a preventative measure to avoid perceived problems when the individual was being transferred to another facility for psychiatric treatment. This restraint was not in response to "an immediate safety situation that places the individual or others at serious threat of violence or injury if no intervention occurs" as required by policy. The documentation associated with this restraint indicated the chemical was administered at 4:00pm. Nurse monitoring occurred at 4:30 and 6:30 which is not in compliance with the frequency of nurse monitoring required by policy. The post restraint consultation by the psychiatrist characterized this restraint as "standard practice." The Personal Support Plan Addendum (PSPA) completed on 7/8/11 to review the restraint reported "the team felt that in order to prevent injury to the Individual and others in the van chemical restraint was necessary to keep the Individual calm." There was no information presented to the Monitoring Team to reflect thoughtful discussion by the PST as to how best to plan a safe transport for the individual to another facility for treatment that might not have required chemical restraint. The Monitoring Team review of documentation led to the conclusion that chemical restraint was the only option considered, and, as expressed by the psychiatrist, considered standard practice. Individual #306 was chemically restrained on 5/9/11 in response to a behavioral crisis. The Restraint Checklist reports numerous interventions that were attempted prior to the chemical restraint; however, neither the Restraint Checklist nor the post restraint PST review documented that physical restraint was considered or attempted prior to the use of a chemical restraint. The psychiatrist did not conduct a post restraint evaluation as required by policy. The psychiatrist also did not attend the post restraint PST meeting. A nurse monitored the individual in accordance with policy. From the documentation provided to the Monitoring Team it appears the use of chemical restraint could possibly have been avoided if one or more methods of physical restraint had been attempted. Facility policies identify a list of approved restraints. Based on the review of 12 restraints, involving eight individuals, 12 (100%) were approved restraints.	
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 was in substantial compliance with this provision of the Settlement Agreement. The Monitoring Team does not concur. The Facility's monitoring data reported 100% compliance with this requirement for each month since the last review. As described below, the review of sampled restraints conducted by the Monitoring Team did not reach the same conclusion. Eight of 12 (67%) of the sample of restraint records reviewed indicated restraint was terminated as soon as the individual was no longer a danger to him/herself or others. Of those that did not, all were individuals with a SPCI.	Noncompliance

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		The Restraint Checklists for Individual #60 and Individual #624 (6/19/11, 6/22/11, and 8/4/11) all reported the release code of J "met safety plan calm criteria and was released" rather than release code L "released immediately because no longer an immediate and serious risk of harm to self/others." Other Individuals with a SPCI were noted to be released from restraint using release code L. This is an important distinction because the SA requires restraint termination as soon as the individual is no longer a danger to him/herself or others which can be before the person is calm. For example, an individual may no longer be a danger to him/herself or others but may be yelling, cursing, or otherwise visibly upset. Presumably being calm would require a time interval, however brief, 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. In each case the FFAD noted the restraint was terminated when the individual was no longer a danger to him/herself or others. The Restraint Checklist is considered the primary source of restraint documentation and data contained in it should not conflict with data in the FFAD document. The other eight crisis intervention restraints in the sample included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself using 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 applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved	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 Facility's self-assessment process relied on the results of internal monitoring. The POI reported PMAB training compliance rates of 95% in April, 2011, 93% in May, 95% in June, and 96% in July. The Facility's policies related to restraint are discussed, in part, in Section C.1. These policies, if consistently applied, should be sufficient to demonstrate compliance with the SA. Review of the Facility's training curricula revealed that it included adequate training and 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 Policy CMGMT-20 (11/5/09) Limitation of Restraint as a Crisis Intervention does	Noncompliance

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	restraint techniques; and adequate supervision of any individual in restraint.	not include specific classes, by reference number, required of staff. In the absence of policy defined required training, the Monitoring Team checked 25 staff training records (selected by picking the fifth name from the bottom of each printout page of the list of employees and referred to as Sample C.2) 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 25 staff in the sample all completed all required training. 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. 98% 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. 98% PBS0100 – Positive Behavior Support These compliance percentages are sufficient to demonstrate substantial compliance with the training component of this provision. As noted in Section C.1 67% 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. This was because it was unclear if interventions included in each SPCI were applied in those restraint episodes in the Monitoring Team's sample. Ensuring that restraint is use only after a graduated risk of less restrictive measures has been exhausted or considered, while continuing to maintain the other processes as described in this provision, is likely to result in substantial compliance.	
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	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 Facility's self-assessment process relied on the results of internal monitoring. The POI reported compliance rates ranging from 80% to 100% depending on the specific requirement being checked.	Noncompliance

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	prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	The Monitoring Team determined that a significant area of noncompliance was the requirement that if medical restraints are used for routine medical or dental care for an individual, the PSP for that individual must include treatments or strategies to minimize or eliminate the need for restraint. The Facility had approved a full time and a part time position in the Behavior Services department designated for desensitization assessment and programming. The full time position had been filled just prior to this review. The part time position remained vacant but the Facility was recruiting to fill the position. These positions were designed to assist in the assessment and evaluation of individuals for desensitization training and also to help develop desensitization training. The DSSLC Policy CMGMT-20 Limitation of Restraint as a Crisis Intervention states that restraint can only be used for crisis intervention. Based on a review of 12 crisis intervention restraint records (Sample C.1), in 12 (100%) there was evidence documenting that restraint was used as a crisis intervention. The Monitoring Team reviewed the 12 crisis intervention restraint records to determine if any restraint techniques were used that were prohibited by the individual's medical orders or ISP. The Monitoring Team was not provided with sufficient information to make this determination. In response to the pre-visit document request the Facility reported "there are currently no individuals identified in which restraint is not to be used under any circumstance." This was insufficient to demonstrate compliance with the section of the SA that requires "No restraint shall be used that is prohibited by the individual's medical orders or ISP". Even for individuals for whom restraint is not entirely prohibited, some forms of restraint may be prohibited, so it is essential the physician document whether there are any limitations or not. The Monitoring Team expected to see a form entitled "Considerations for Implementing Restraint Medical/Physical." This form, in use at some other facilities, consists of two parts. The top half is completed and signed by a physician noting whether or not there are medical conditions to be taken into consideration with respect to restraint use with the individual. The bottom half is completed and signed by a QMRP noting whether or not there are other considerations to take into account with respect to restraint use with the individual. This typically occurs at a PST meeting. In some, but not all, instances the DSSLC used a form that recorded some of this type of information. The processes currently used at DSSC that could, with some modification, lead to compliance with this requirement were described as: If an Individual has an SPCI a physician/nurse practitioner completes a form entitled "Physician/Nurse Practitioner's Approval (Restrictive Interventions)"	

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		acknowledging a review of the Individuals medical history and current physical condition, and, indicating they do, or do not, see any medical or pharmacological contraindications to the use of the specific restraint described in the SPCI. Four Individuals in Sample C.1 had an SPCI. Three (75%) had the above referenced form in the documentation file prepared for the Monitoring Team. The restraint for Individual #50 did not. The forms for the other three individuals were dated 8/11/11 and all restraints involving these individual predated 8/11/11. It was unclear to the Monitoring Team whether the completion of this form was intended to be an annual event or not. If so, the Facility should have provided the form for the year that included the restraint dates in the sample. Therefore, none of this documentation is sufficient to validate compliance with this part of the SA. If an individual does not have an SPCI the form referenced above is not used; however, a physician order is required for each restraint. This was present for each restraint of an individual without an SPCI; however, in each restraint this order was written after the restraint was initiated and in all but one instance, well after the restraint episode concluded. The intent of this part of the SA is to ensure that the medical history of an individual is reviewed and a physician determines that there is, or is not, anything in an individual's medical history or current condition (at the time of the assessment) that would preclude or restrict use of restraint. The documentation presented is not sufficient to validate compliance with this part of the SA. <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 #170, #425 (4/13), #488 (5/24), #507, #554, #240 (7/25), #656, #472, #435, #601 (4/12), #570, #199, #167, #545, #210, #624, #395, #247, #722, #590, #612, and #526. 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 #15, #21, #35, #165, #181, #199, #493, #537, #639, and #740. 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	

#	Provision	Assessment of Status	Compliance
		of medical restraint for the individual (including data sheets if a program was developed and implemented) for all ten individuals cited above. During the last review Facility staff described an assessment process being planned to determine the need for desensitization or other interventions for those individuals subjected to pre-treatment sedation. At that time an assessment document was in draft form which relied on a determination by dental clinic personnel to assess the ability of individuals to cooperate with routine dental procedures. This draft eventually became a formal dental department procedure on 8/1/11. DSSLC Dental Services policy DS-15: Need for Dental Desensitization , which requires that dental staff document each individual's behavior to determine if a person is "compliant" with no need for desensitization training; "moderately compliant" which would result in a recommended action of visiting the dental clinic when not scheduled for dental work, and/or having the Personal Support Team (PST) develop informal or formal desensitization training; or "fully non-compliant" which would result in a recommended action of asking behavioral services intervention for a formal desensitization plan. One of the medical restraints in the sample was after 8/1/11 (Individual #210). There was no evidence presented to the Monitoring Team to indicate this expected procedure occurred. There was no additional evidence provided to the Monitoring Team to substantiate implementation of this policy. The Monitoring Team asked for the five most recent support plans to reduce the need for dental medical restraint, and, the five most recent support plans to reduce the need for medical procedure medical restraint. The Facility responded that it did not have five examples of each type but rather a total of seven which were provided to the Monitoring Team. These were for Individuals #361, #416, #429, #445, #648, #699, and #755. Inconsistent implementation of these support plans was evident. For example, quarterly reviews in each instance reported no data available, the wrong data being reported, or similar entries suggesting these support plans were not implemented, not implemented timely, not implemented consistently, and/or not implemented correctly. The need for improved work processes associated with medical restraint, especially dental pre-treatment oral sedation, is evident.	
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	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 Facility's self-assessment process relied on the results of internal monitoring. The POI reported compliance rates ranging from 80% to 100% depending on the specific requirement being checked. The Facility reported in its POI that when auditing identified documentation errors, on the spot training had been provided to the staff making the	Noncompliance

#	Provision	Assessment of Status	Compliance
	15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	error. Additionally, nurse case managers received training on fundamental aspects of restraint, especially related to monitoring during the restraint, and the use of the Sedation Checklist and Outpatient Medical Consultation/Procedure Form for medical restraints. Physicians received training on the use of the Order form for Medical/Dental restraint and the Sedation Checklist. The order form includes specific prompts to include the schedule and type of monitoring required during medical/dental restraint. 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. This training appeared to be sufficiently detailed, and competency based, to ensure staff designated as restraint monitors can reasonably be expected to competently perform the duties of a restraint monitor. 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. Material was provided to the Monitoring Team from the Behavior Services Department in response to a document request asking for curricula for training conducted by the Behavior Services Department separate from formal CTD/DADS classes. The Facility had conducted training directed at facility specific practices associated with restraint use and related documentation requirements. Sign-in sheets were provided to confirm that:	

#	Provision	Assessment of Status	Compliance
		1. QMRPs received facility specific restraint training on 7/1/11. Training content included the responsibilities of PSTs in reviewing each episode of restraint. 2. Psychology staff received facility specific training on post restraint assessment, the restraint checklist, and in testing staff knowledge on 7/22/11 and 8/5/11. 3. Nursing staff received facility specific training on nursing responsibilities related to restraint on 8/24/11. 4. DCPs received training on the Fundamental Aspects of Restraint, a curriculum developed by the Behavioral Service department. This occurred over multiple dates in July and August, 2011. Based on a review of 12 non-medical restraint records (Sample C.1), a face-to-face assessment was conducted in 12 of 12 incidents of restraint (100%) by an adequately trained staff member. In 12 instances (100%), the documentation on the FFAD showed that an assessment was completed of the application of the restraint. In 12 instances (100%), the documentation on the FFAD showed that an assessment was completed of the circumstances of the restraint. The Monitoring Team was pleased to learn of a new process the Facility had in August 2011 that required a psychologist to review the application and circumstances of crisis intervention restraints when the restraint is not part of a SPCI (as a further review in addition to the debriefing). This is done by reviewing documentation and interviewing staff involved in the restraint episode. One restraint in the sample occurred after August 1st and a "Behavior Services Staff – Debriefing Post Restraint" document was provided to the Monitoring Team. This document provided good information on the application and circumstances of the restraint but the document did not indicate who did the review, the date of the review, and whether or not the review received supervisory review. Subsequent examples (outside of the restraint sample) were provided to the Monitoring Team and these included the name of the person conducting the review and the date of the review. The Facility is to be commended for initiating this additional review process. None of the 12 crisis intervention restraint records in the sample indicated an alternative physician-ordered monitoring schedule. Separate from the sample there were three instances where a physician had ordered an alternative schedule of monitoring (Individuals #336. #337 and #383). The Facility reported no instance of restraint occurring while an individual was away from the Facility.	

#	Provision	Assessment of Status	Compliance
		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. To address this SA requirement (and others), the Facility had implemented an Order Form for Medical/Dental Sedation/Restraint, effective 8/5/11. In order to test initial implementation the Monitoring Team asked for all completed forms from 8/6/11 through 8/31/11. None were provided. The Facility did produce one completed form (for Individual # 665) which was dated 9/12/11. It would appear that implementation of this new, and very necessary, process has been slow. The Monitoring Team will look for consistent use of this process in its next review. Based on a review of 12 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 11 (91%) of the instances of restraint. Listed below are Individuals and date of each restraint record where this did not occur: o Individual #217: 4/17/11 ▪ Monitored and documented vital signs in seven (58%). Listed below are Individuals and date of each restraint record where this was not present: o Individual #580: 8/7/11 (Individual refused to allow nurse to complete initial set of vital signs) o Individual #50: 4/18/11 (Individual refused to allow nurse to complete vital sign assessments.). o Individual #306: 6/15/11 (Individual refused to allow nurse to complete vital sign assessment.) o Individual #537: 4/13/11 (Individual noted to be too aggressive to allow full set of vital sign assessment.) o Individual #217: 4/17/11 (Individual refused to allow nurse to take initial full set of vital signs assessment. Thereafter vital signs were not taken until one hour later after the initial attempt.) For the above individuals there was documentation that the nurse attempted to complete vital signs within 30 minutes and every 30 minutes thereafter but the individuals refused some or all of the vital signs to be taken. ▪ Monitored and documented mental status in 10 (83%). Listed below are Individuals and date of each restraint record where this was not present: o Individual # 624: 5/18/11 at 6:39 p.m. o Individual # 306: 6/15/11 ▪ Based on documentation provided by the Facility, none (0%) of the restraint incidents had occurred off the campus of the Facility in the last six months, so there were no opportunities for the Monitoring Team to review monitoring of off-campus restraints.	

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C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	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 due to documentation issues associated with medical restraint. The Facility's self-assessment process relied on the results of internal monitoring. The POI reported compliance rates ranging from 75% to 89% depending on the specific requirement being checked. In the crisis intervention restraint sample reviewed by the Monitoring Team the rate of compliance was 100% in every category but one. This review of crisis intervention restraints, along with the Facility's monitoring process to identify and correct documentation errors, is sufficient to merit a finding of substantial compliance with respect to crisis intervention restraint use. As noted below the Monitoring Team identified compliance issues with respect to medical restraint use that must be addressed for this provision to achieve a rating of substantial compliance. A sample (Sample C.1) of 12 Restraint Checklists for individuals in crisis intervention restraint was selected for review. The following compliance rates were identified for each of the required elements: • In 12 (100%), continuous one-to-one supervision was documented. • In 12 (100%), the date and time restraint was begun was documented. • In 12(100%), the location of the restraint was documented. • In 12 (100%), information about what happened before, including the change in the behavior that led to the use of restraint was documented. • In 12 (100%), the interventions taken by staff prior to the use of restraint were documented and were adequate for post restraint review. • In 12 (100%), the specific reasons for the use of the restraint were documented. • In 12 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated on the restraint checklist. • In 12 (100%), the names of staff involved in the restraint episode were indicated on the restraint checklist. Five of the restraints in the sample included use of the horizontal side-lying technique. In each of these restraint episodes at least two staff were listed as applying the restraint. • The Restraint Checklist documented observations of the individual and actions taken by staff while the individual was in restraint, including: o In 12 (100%), the observations documented at least every 15 minutes and at release. None of the restraints in the sample exceeded 15 minutes. Most were of very short duration. o In 12 (100%), the specific behaviors of the individual that required continuing restraint were noted. o Because of the short duration of all 12 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		possible, to drink fluids, and to use a toilet or bed pan. o In 12 (100%), the level of supervision provided during the restraint episode was recorded on the restraint checklist. • In 12 (100%), the date and time the individual was released from restraint was recorded on the restraint checklist. • In 11 (92%), 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 Individual #217 (4/17/11). In a sample of 12 records (Sample C.1), FFADs had been completed for 12 (100%). These forms contained little narrative information but were generally complete in checking all the required boxes on the form. The attention to detail required to complete this documentation accurately was much improved compared to that noted in the last review. Occasional documentation discrepancies were noted. For example, Individual #580 was restrained for one minute at 8:33 pm. The FFAD indicates yes to the question "medications given in the time period prescribed if in restraint at med pass." It is highly unlikely this individual received medication during the one minute duration of this restraint. A sample of 22 instances of individuals who received medical restraint (pre-treatment oral sedation) was reviewed (Sample C.3). The documentation provided to the Monitoring Team with respect to the 22 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 that in the case of oral sedation a Pre/Active/Post Sedation checklist is to be used to document various aspects of the restraint application and that the REACT scoring system is to be used to measure sedation recovery. The material provided to the Monitoring Team was insufficient to determine compliance with these policy requirements.	

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		Restraint files for a sample (Sample C.3) of pretreatment sedation medical restraint for medical procedures for Individuals #170, #425 (4/13), #488 (5/24), #507, #554, #240 (7/25), #656, #472, #435, #601 (4/12), #570, #199, #167, #545, #210, #624, #395, #247, #722, #590, #612, and #526 were prepared for the Monitoring Team with the following instructions: "for each selected restraint include restraint checklist, face to face debriefing documents, medical orders, physician specified monitoring schedule, standard facility protocol for monitoring medical restraint (if applicable), PSP information regarding the development and implementation of plans to minimize the use of medical restraint for the individual, including completed data sheets if a program was developed and implemented, evidence related to all steps of the facility restraint review process including administrative and programmatic follow-up, and any other information you feel would be helpful to the monitor in understanding the circumstances associated with the restraint use." Most files prepared by the Facility were incomplete. The 22 files put together for the Monitoring Team contained dissimilar information. Some contained a "Pre/Active/Post Sedation Checklist" and others did not. Most did not contain a REACT scoring sheet, and those that did were incomplete. In one instance only two of the required four pages of the checklist were included. This leads the Monitoring Team to the conclusion that the DSSLC still does not have an organized system for the management of pre-treatment sedation that will facilitate compliance with the SA.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:	According to DSSLC documentation, during the six-month period prior to the on-site review, a total of seven individuals were placed in restraint more than three times in any rolling thirty-day period. A sample of all seven of these individuals (100%: Individuals #50, #127, #217, #336, #337, #381, and #624) was selected for review to determine if the requirements of the Settlement Agreement were met. The following documents were reviewed: PSPs, PSP addenda, PBSPs, PBSP progress notes, and restraint documentation. The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	For seven of the individuals reviewed (100%), individuals' teams met to discuss the restraints. For none of the individuals/instances reviewed (0%), individuals' teams reviewed the individual's adaptive skills. The following are examples of where teams failed to do this adequately:	Noncompliance

#	Provision	Assessment of Status	Compliance
		• For Individual #217, the most recent assessment of adaptive behavior was completed on 1/24/1989. • For Individual #336, documentation reflected no indication of an adaptive assessment having ever been administered. For seven of the individuals reviewed (100%), individuals' teams reviewed the biological, medical and psychosocial factors. The following are examples of individuals who whom this was done appropriately: • For Individual #337, documentation reflected that the PST met frequently, often multiple times per week, to review the individual's adaptive skills and biological, medical, psychosocial status. • For Individual #381, documentation reflected that the PST met frequently to review the individual's adaptive skills and biological, medical, psychosocial status.	
	(b) review possibly contributing environmental conditions;	For five of the individuals reviewed (71%), individuals' teams reviewed the possibly contributing environmental conditions. The following are examples of individuals for whom this was done appropriately: • For Individual #306, a comprehensive functional assessment was completed on 5/5/11. The PST discussed elements of the functional assessment following the restraint applications. • For Individual #381, a functional assessment was completed on 4/13/11. Documentation reflected that the functional assessment was routinely used as part of the restraint application review process. The following are examples of where teams failed to do this adequately: • For Individual #336, the most recent functional assessment was completed in January of 2011. Information presented in the functional assessment, however, was collected between 2007 and 2009. It was likely that information from that long ago was not applicable to current circumstances. • For Individual #381, a functional assessment was completed on 4/13/10. Documentation reflected that the functional assessment was routinely used as part of the restraint application review process without further functional assessment even in light of restraint use..	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	For five of the individuals reviewed (71%), 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 #306, a comprehensive functional assessment was completed on 5/5/11. Elements of the functional assessment were discussed by the PST	Noncompliance

#	Provision	Assessment of Status	Compliance
		following the restraint applications. The following are examples of where teams failed to do this adequately: • For Individual #336, the most recent functional assessment was completed in January of 2011. Information presented in the functional assessment, however, was collected between 2007 and 2009. It was likely that information from that long ago was not applicable to current circumstances. • For Individual #381, a functional assessment was completed on 4/13/2011. Documentation reflected that the functional assessment was routinely used as part of the restraint application review process without further functional assessment even in light of restraint use..	
	(d) review or perform functional assessments of the behavior provoking restraints;	The process of assessing the role of environmental variables in the display of undesired behaviors at DSSLC was included in the functional assessment. Information presented in Provisions c.7(b) and (c) above also applied to this element.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	For seven of the individuals reviewed (100%), the individual had a PBSP. Of the seven individuals in the sample who had PBSPs, the following was found: • Five (71%) were based on the individual's strengths; • Seven (100%) specified the objectively defined behavior to be treated that led to the use of the restraint; • None (0%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint; and • One (14%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. The following are examples of individuals for whom adequate PBSPs were in place: • For Individual #217, the behavior assessments were thorough and included a comprehensive discussion of factors contributing to the behavior requiring restraint. It was therefore likely that the PBSP was based upon valid assessments. The following are examples of individuals had inadequate PBSPs: • For Individual #336, the most recent functional assessment was completed in January of 2011. Information presented in the functional assessment, however, was collected between 2007 and 2009. It therefore could not be determined that the current PBSP was based upon current and valid assessments. The Safety Plans of the individuals in the sample were reviewed. The following represents the results:	Noncompliance

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In three out of three of the Safety Plans reviewed (100%), the type of restraint authorized was delineated;
In three (100%), the maximum duration of restraint authorized was specified;
In three (100%), the designated approved restraint situation was specified; and
In three (100%), the criteria for terminating the use of the restraint were specified.

</td><td></td></tr>
<tr><td></td><td>(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</td><td>
In February of 2011, DSSLC implemented the first phase of a process to measure interobserver agreement (IOA) for PBSP data. As the IOA procedure was implemented only a few weeks prior to the March 2011 site visit, it was not possible to effectively review the IOA data at that time.

During the current site visit, DSSLC provided documentation of 617 IOA observations conducted between 2/10/2011 and 6/24/2011. The results of those observations are presented below.

<table>
<tr><th>Location</th><th>Observer Agreement</th><th>Number of Observations</th></tr>
<tr><td>503</td><td>33%</td><td>3</td></tr>
<tr><td>504</td><td>51%</td><td>9</td></tr>
<tr><td>505</td><td>51%</td><td>52</td></tr>
<tr><td>506</td><td>62%</td><td>25</td></tr>
<tr><td>507</td><td>71%</td><td>88</td></tr>
<tr><td>508</td><td>89%</td><td>3</td></tr>
<tr><td>509</td><td>96%</td><td>6</td></tr>
<tr><td>510</td><td>100%</td><td>1</td></tr>
<tr><td>511</td><td>84%</td><td>61</td></tr>
<tr><td>512</td><td>80%</td><td>72</td></tr>
<tr><td>513</td><td>39%</td><td>4</td></tr>
<tr><td>514</td><td>76%</td><td>22</td></tr>
<tr><td>515</td><td>80%</td><td>30</td></tr>
<tr><td>520</td><td>74%</td><td>27</td></tr>
<tr><td>522</td><td>77%</td><td>24</td></tr>
<tr><td>523</td><td>74%</td><td>26</td></tr>
<tr><td>524</td><td>68%</td><td>2</td></tr>
<tr><td>525</td><td>84%</td><td>44</td></tr>
<tr><td>526</td><td>78%</td><td>34</td></tr>
<tr><td>527</td><td>83%</td><td>27</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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<tr><td>528</td><td>87%</td><td>38</td></tr>
<tr><td>ARC</td><td>83%</td><td>6</td></tr>
<tr><td>ETC</td><td>100%</td><td>1</td></tr>
<tr><td>Gym</td><td>96%</td><td>9</td></tr>
<tr><td>ICD</td><td>67%</td><td>3</td></tr>
<tr><td>Facility Average</td><td>75%</td><td>617</td></tr>
</table>

The initiation of IOA observations was a positive step by DSSLC. The initial results must be reviewed as preliminary, however. Although an average of 75% agreement over 617 observations was good, the total observations conducted over 134 days comprised an average of only 4.6 observations per day across the entire facility. Furthermore, the number of observations for several locations was very low. As a result, the Facility will need to increase the scope of IOA observations in order to reach substantial compliance with the SA.

For three of the individuals reviewed (43%), the individual's treatment integrity checks showed that the PBSP was implemented with a high level of treatment integrity.</td><td></td></tr>
<tr><td></td><td>(g) as necessary, assess and revise the PBSP.</td><td>In three of the records reviewed (43%), there was documentation that the individual's PBSP had been revised as appropriate. These were instances where the PBSP was reviewed and revised shortly after the application of restraint. In these instances, however, the revision was included as part of the annual PSP process, and it was not possible to determine if the PBSP would otherwise have been reviewed or revised.

The following is an example of where teams failed to do this adequately:
• For Individual #445, the PBSP was in excess of one year old. Behavior data did not reflect benefit from the intervention, yet the PBSP was extended for an addition six months on 7/20/2011.</td><td>Noncompliance</td></tr>
<tr><td>C8</td><td>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.</td><td>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 Facility's self-assessment process relied on the results of internal monitoring. The POI reported compliance rates ranging from 80% to 100% depending on the specific requirement being checked.

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</td><td>Noncompliance</td></tr>
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		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 usually consists of verbal reports from staff. It is reviewed that same day by the Incident Management Review Team (IMRT), again usually based on verbal reports from staff, either the Unit Director, behavioral services staff, or both. It appears these reviews "ascertain the circumstances under which such restraint was used" with respect to time, place, and type of restraint. The Monitoring Team is of the belief (based on the requirement in the provision that "ISPs shall be revised, as appropriate") that to come into compliance with this provision of the SA, post restraint review should be sufficiently clinically oriented such that a PST can determine whether or not PSP revisions are needed (including revisions to the PBSP), and if so, revisions are made. The new process that the Behavior Service department has implemented where behavioral services staff review documentation and interview staff involved in the restraint should help in this regard. Restraint reviews were documented in IMRT meeting minutes but almost always noted just the date and time the restraint occurred and that a review occurred at IMRT. No crisis intervention restraints occurred during the review so the Monitoring Team was not able to observe a Unit restraint review or a specific IMRT restraint review. There is space on the Restraint Checklist and the FFAD to document that a unit review took place and the date. This was properly documented in all 12 (100%) restraints in Sample C.1. All 12 (100%) documentation files contained evidence that an IMRT review occurred. The Monitoring Team does not believe these reviews are substantive enough to comply with this provision of the SA. 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." PSPAs were not provided for two individuals who did not have a SPCI (Individuals #250 and #580). Additionally, the PSPA provided for Individual #306 was dated 5/11/11 for a restraint that occurred 6/15/11. For those Individuals who had a PBSP, restraint records contained a Behavior Support Plan Progress Note. These are completed monthly by Behavioral Service staff and will discuss, among other things, restraint use. Without a PSPA or other PST documentation, the Monitoring Team cannot accurately assess the degree to which a restraint episode was reviewed and whether or not any PSP changes resulted from the review. The SA requires that the Facility review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. This review is required to take place within three business days of the start of each instance of	

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		restraint. The Facility was not following this SA requirement for Individuals #336, #337, and #381. Rather, the Facility conducted a weekly review of all restraints experienced by these individuals during the prior seven days (five business days). The daily restraints for each Individual were noted in IMRT minutes but these reviews are not sufficient to "ascertain the circumstances" as noted previously. The Restraint Reduction Committee meets monthly. In reviewing minutes, and through observation of the meeting held during the review, it is evident the committee engages in substantive review, problem solving, and the development of specific recommendations. Meetings usually also include a case study which is typically the most difficult behavioral/restraint case at the time of the meeting. The Quality Assurance/Quality Improvement Council includes a review of SA Section C compliance on its agenda on a rotating basis. This would not typically include any discussion of an individual episode of restraint but does ensure a broader base of general review of restraint data and restraint practices at the DSSLC.	

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

1. DSSLC restraint policies, especially in regard to medical restraint, need to be fully and uniformly implemented (Provision C1).
2. Monitoring of implementation of medical restraints needs to intensify (Provisions C.1, C.4, C.5, and C.6).
3. Restraint release criteria and documentation needs clarification with additional staff training if necessary (Provision C.2).
4. Additional training of staff on medical restraint procedures and documentation is needed (Provision C.1, C.4, C.5, and C.6).
5. The post-restraint review process needs to be more clinically oriented (Provision C.8).
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. (Provision C.7)
7. PSP Addendums should reflect on and document active treatment efforts being made. (Provision C.7)
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. (Provision C.5)

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.

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 9/7/11 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 1/31/11 5. DSSLC Policy CMGMT-01A Protection from Harm – Abuse, Neglect, and Exploitation 7/30/10 6. DSSLC Policy CMGMT-01B Protection from Harm – Incident Management 7/1/11, including Exhibit A-Discovered Injury Investigation Worksheet, Exhibit B-Guidelines for Securing Evidence, Exhibit D-Client Injury Reporting Procedure, Exhibit H-Discovered Injuries, Exhibit J-Serious Injuries, and Exhibit K-Due Diligence 7. Minutes of Department of Family and Protective Services (DFPS)/Office of the Inspector General (OIG) meetings 5/19/11 and 8/2/11 8. Training Curriculum for Course ABU0100 Abuse and Neglect 7/13/09 9. DSSLC Retraining Curriculum for Course ABU0100 Abuse and Neglect 7/20/10 10. Sample of Employee Training Records – Sample C.2 11. DADS Report MHMR0102 Percent of All Employees Completing Courses of Training Program 9/1/11 12. Sample of Acknowledgment of Responsibility for Reporting Abuse, Neglect, and Exploitation employee forms. 13. DSSLC Annual Employee Registry Check and Fingerprint Criminal History Check dated 9/21/11 14. DSSLC report on volunteer background checks (undated) 15. "You Have the Right" poster 7/17/09 16. "Report Abuse or Neglect" poster 4/05 17. "Prevent Abuse & Neglect Poster" (undated) 18. Current mailer to LARs regarding abuse, neglect, and exploitation 19. Incident Management Review Team Meeting minutes for 6/22/11, 6/29/11, 7/6/11, 7/13/11, 7/20/11, 7/27/11, 8/3/11, 8/10/11, 8/17/11, 8/24/11, 8/31/11, 9/19/11, 9/21/11 20. Allegation, Injury, and UIR Trend Report 8/31/11 21. Individual Training Records for Facility and Department of Family and Protective Services (DFPS) Investigators 22. DFPS case log 4/1/11 to 9/19/11 23. Document labeled "Commencement of DFPS Investigation" undated 24. OIG case log 4/1/11 to 9/19/11 25. Log of employees reassigned from client contact 4/1/11 to 7/30/11 26. List of employees terminated due to background checks 27. Unusual Incident log 4/2/11 to 9/15/11 28. Serious Injury Report 4/2/11 to 8/23/11 29. Witnessed Injury Log 4/2/11 to 9/15/11

	30. Discovered Injury Log 4/2/11 to 9/15/11 31. Peer caused injury log 4/2/11 to 8/23/11 32. Discovered Injury Investigation for Individuals #85, #372, #580, #672, #706, and #722 33. UIRs related to serious injury investigations: 11-189, 209, 216, 247, and 269 34. Other UIRs: 11-186, 187, 231, 234, 245, 262, and 283 35. DFPS Investigation Files for compliance review sample: 39406527, 39887247, 39999827, 40016528, 40138607, 40210400, 40212629, 40225390, 40227051, 40230446, 40232104, 40232350, 40236905, and 40237234 36. Additional DFPS Investigation files: 40234630, 40225390, 40230446,, 39691491, 39034876, 40210400, and 40266149 37. DFPS cases referred back to the Facility: 40151827, 40228401, 40238733, 38900595, 39674607, 39783627, and 39851988 38. Under Reporting Audit reports for July and August, 2011 39. Rights Poster Audit reports for July and August, 2011 40. Self-Advocacy meeting minutes: 4/29/11 and 5/27/11 41. 2011 Guardian/LAR Satisfaction Survey 42. CMS 2567s since the last 43. QA/QI committee meeting minutes: 6/20/11, 7/21/11, 8/4/11 and 8/18/11 **People Interviewed:** 1. Deb Salsman, Director of Incident Management 2. Jeron Dotson, Incident Management Coordinator 3. Lori Powell, Director of Quality Assurance 4. Ken Horstman, Director of Residential Services 5. Richard Colbert, OIG Investigator 6. Mark Schobert, DFPS Investigator 7. Simona Armendariz, DFPS Investigator 8. Five Direct Care Professionals **Meetings Attended/Observations:** 7. Incident Management Team (IMRT) 9/19/11 8. Facility Review Authority 9/19/11 9. Restraint Reduction Committee 9/22/11 10. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 9/20/11 11. Self-Advocacy Council officers meeting 9/21/11
	Facility Self-Assessment: The DSSLC POI reported substantial compliance with all five provisions in Section D of the SA. The Monitoring Team was able to substantiate compliance with two of the five provisions. The Monitoring Team concurred with the 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. The Monitoring Team determined DSSLC

	was in substantial compliance with seven of the nine components in D.2. Components not found in compliance included Provision D.2.a (reporting of alleged abuse primarily related to investigation of discovered injuries) and Provision D.2.g. (law enforcement referrals). The DSSLC reported substantial compliance with Provision D.3. The Monitoring Team determined DSSLC was in substantial compliance with seven of the ten components in Provision D.3. Components not found in compliance included Provisions D.3.e (timeliness of commencement of DFPS investigations), D.3.f. (conduct of Facility investigations) and D.3.g (review of investigations). The DSSLC reported substantial compliance with Provision D.4. The Monitoring Team did not find sufficient evidence to concur. The Facility apparently did not have a systematic methodology for determining its self-assessment ratings. Several areas noted as noncompliant in the last review were noted as compliant even though little had changed (e.g. timely reporting of serious injuries and content of trend reports). The Facility cited several examples in its POI of data resulting from its monitoring efforts. These data were apparently used, at least in part, to determine the Facility's self-assessment compliance rating.. Using monitoring data to determine the status of compliance is a positive step; however, the Facility must be more assertive in assuring the accuracy of its monitoring data. There are several instances noted in this report that demonstrate a significant variance between what DSSLC monitoring data noted as compliance rates compared to what the Monitoring Team, through its samples, determined as compliance rates. Nevertheless, the Facility is close to achieving substantial compliance with this section of the SA, especially in the areas for which it has direct authority.
	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. As with any complex system at a large organization there are sub-systems that do not always perform at an optimal level. At DSSLC most do and those that have an occasional lapse are usually self-identified through monitoring/auditing with timely corrective measures initiated. Management systems are under continual refinement to self-identify problem areas that need improvement. 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. The Monitoring Team determined DSSLC was in substantial compliance with seven of the nine components in Provision D.2. Components not found in compliance included Provisions D.2.a (timely reporting of incidents including serious injuries) and D.2.g. (law enforcement referrals). Both are easily correctable and the Monitoring Team expects to find compliance at the next review. The Monitoring Team determined DSSLC was in substantial compliance with seven of the nine components in Provision D.3. Components not found in compliance included Provisions D.3.e (timeliness of

	commencement of DFPS investigations) and D.3.f. (conduct of Facility investigations). DSSLC needs to continue 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. The knowledge of Direct Care Professionals with respect to abuse and neglect was much improved from that observed at the previous review. Compliance with required background checks was confirmed.

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D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	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. DSSLC policy CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10), requires that staff 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. Staff interviewed during the review were clear in their reporting responsibilities. Finally, nothing discovered in the course of this review suggested anything but a zero tolerance policy towards abuse and neglect, or, any instances of failure to report suspected abuse or neglect. The Monitoring Team has determined that the DSSLC was in substantial compliance with this provision of the SA.	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	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 Monitoring Team determined that two components rated as in substantial compliance by the DSSLC were not.	

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	shall require:	DSSLC policies CMGMT 01A Protection from Harm – Abuse, Neglect, and Exploitation (7/30/10) and CMGMT 01B Incident Management (7/1/11) are intended to address this provision of the SA.	
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	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 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 Facility provided data to the Monitoring Team for a six month reporting period of 3/1/11 through 8/31/11. During this six month period allegations reported to DFPS were as follows: 1. 95 abuse allegations. The disposition by DFPS of these 95 allegations was: 10 were substantiated, 63 were unconfirmed, six were inconclusive, six were unfounded, ten were referred back to the Facility as the allegation did not meet DFPS criterion for investigation. 2. 77 Neglect allegations. The disposition by DFPS of these 77 allegations was: 18 were substantiated, 34 were unconfirmed, three were inconclusive and 25 were referred back to the Facility as the allegation did not meet DFPS criterion for investigation. 3. Four exploitation allegations. All four were referred back to the Facility as the allegation did not meet DFPS criterion for investigation. Two samples of investigations were selected for review. These included: Sample D.1 of 14 DFPS investigations of abuse, neglect, and/or exploitation between 4/1/11 and 9/7/11. This sample included the following DFPS investigation reports: 39406527, 39887247, 39999827, 40016528, 40138607, 40210400, 40212629, 40225390, 40227051, 40230446, 40232104, 40232350, 40236905, and 40237234. This represented a 20% sample. The sample was selected by working back from the most recent investigation and selecting the first three cases of confirmed physical abuse, first three cases of unconfirmed physical abuse, first three cases of confirmed neglect, first three cases of unconfirmed neglect, and two cases with inconclusive findings (one allegation of abuse and one allegation of neglect). Sample D.2 of five facility investigations of serious injuries. DSSLC provided a report	Noncompliance

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		entitled Serious Injury Report, which listed serious injuries to individuals from 4/2/11 to 8/23/11. From this report the Monitoring Team was able to determine the DSSLC had 21 serious injuries during this time period. From these 21, five were selected for sample D.2 to assess the adequacy of the facility investigation process. Three of those selected were discovered injuries and two were witnessed injuries. In reviewing Sample D.1 (DFPS case reports) seven of the 14 investigations noted a date and time the incident occurred (the other seven noted "unknown" which was appropriate given the nature of the allegation). Four of the seven (57%) indicated 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: 40138607, 40230446, 40016528, and 40237234. Some reporting was only slightly more than one hour. For example, for investigation 40230446 the time noted in the DFPS case report between the incident occurring and reporting of the incident to DFPS was 70 minutes. The Facility reported that some instances of apparent late reporting were thought to be the result of the person at the facility telephonically reporting an incident being placed on hold for a period of time and DFPS intake staff reporting the time they talked to the reporter, not the time the call came in. This was presented to the Monitoring Team as a hypothesis. There is not any documentation, case by case, to validate this hypothesis. DADS and DFPS may wish to examine this issue closer. Furthermore, these data do not match the data provided in the POI. The Monitoring Team used source data from the DFPS case summary sheets. The Facility may wish to compare its data against the DFPS case summary sheets to determine whether it should make changes in its documentation of reporting and of timeliness of reporting. In reviewing Sample D.2 (serious injuries) one of five (20%) were reported immediately (within one hour) to the Facility Director/designee. Those that were not reported within one hour included UIRs 189, 209, 247, and 269. An additional element of properly reporting allegations of abuse and neglect is the investigation of non-serious discovered injuries. These investigations are conducted to determine, among other things, whether abuse and neglect can be ruled out as a cause, or a contributing factor, of the injury. The Monitoring Team reviewed five Discovered Injury Investigation Worksheets. The information to be collected on these worksheets was comprehensive; however, the collection of information by the staff completing the worksheet was not. For example, the response to the query "what does the review of the one year injury history reveal" was left blank in three worksheets. The others contained little information to indicate much of a review; for example one entry was "similar injury." The person conducting the investigation is required to note his or her name and title on the worksheet as well as the date the worksheet is prepared. In no case was the	

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		person's title noted. In some cases the worksheet was not dated. The Worksheet does not organize and present information in a manner that leads to a conclusion one way or the other that abuse/neglect is suspected, and if so, that it was (or will be) reported. It was reported that these investigations are conducted by unit staff, and the document and any related documentation is not reviewed external to the residential unit. It is apparent to the Monitoring Team that little review of these investigations occurred. The review of investigations of discovered injuries, including non-serious injuries, is an important process to ensure all instances of possible abuse and neglect are discovered and reported.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	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. Based on a review of the 14 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 4/1/10. 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 not resigned. Review of 14 investigation files included in Sample D.1 showed there were no instances where staff that had been removed from direct contact had been subsequently reinstated prior to completion of the investigation. Based on a review of the 14 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. The Monitoring Team has determined that the DSSLC was in substantial compliance with this component of the SA.	Substantial Compliance
	(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	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 Policy CMGMT 01A requires that all staff complete class ABU0100 Abuse and Neglect, and Policy CMGMT 01B requires that all staff complete class UNU0100 Unusual	Substantial Compliance

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	documentation indicating completion of such training.	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 recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. Review of 25 staff records (Sample C.2), showed that 25 (100%) of these staff had completed competency-based training on abuse and neglect and unusual incidents prior to working directly with individuals. All 25 staff had completed both training classes within the last 12 months. Based on an interview of five staff responsible for the provision of supports to individuals, ▪ All were able to list signs and symptoms of abuse, neglect, and/or exploitation with sufficient depth to demonstrate competency of understanding; and ▪ All were able to describe the complete reporting procedures for abuse, neglect, and/or exploitation. The Monitoring Team has determined that the DSSLC was in substantial compliance with this component of the SA.	
	(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	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. The Monitoring Team requested copies of the forms that document compliance for staff hired during the two full months prior to the on-site review. Based on a review of those forms, 142 of 142 (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. A sample of 25 staff (Sample C.2) was randomly selected to determine if annual acknowledgements had been signed. Twenty-four of 25 (96%) had current signed	Substantial compliance

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	Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	statements. This was sufficient to establish substantial compliance. Through document review and interview the Monitoring Team did not discover any instance of a mandatory reporter failing to report abuse or neglect. Four instances of late reporting were noted in Section D.2.a of this report. None were identified by the Facility through its management review process of incidents. Consequently, no personnel action was taken in any instance of late reporting. While this component of the SA relates to failure to report (as opposed to late reporting) it is important that the Facility identify instances of late reporting and follow-up accordingly. The Monitoring Team has determined that the DSSLC was in substantial compliance with this component of the SA.	
	(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 concurs. DSSLC had initiated additional actions directed at this component of the SA since the last review. Materials are provided to LARs prior to each individual's PSP meeting. In talking to two individuals at the Self-Advocacy meeting, the Monitoring Team, through conversation, determined that at least these two individuals could describe what they would do if someone hurt them, or they had a problem with which they needed help. One serious incident, an allegation of physical abuse, had been noted as having been reported by the parent of an individual living at the DSSLC. This suggests that at least this family member was aware of reporting procedures. Additionally, the Facility's self-advocacy meeting minutes reported an extensive presentation by the Facility Lead Investigator on abuse/neglect reporting at the 4/29/11 meeting, and an extensive presentation by a representative from Disability Rights Texas at the 5/27/11 meeting. Monitoring Team members attended several PSP meetings in the course of the review. These are identified in several sections of this report. The Monitoring Team did not observe presentation of information, or discussion, of abuse reporting. Doing this would further serve the purpose of validating ongoing compliance with this component of the SA in future reviews. The Monitoring Team has determined that the DSSLC was in substantial compliance with this component of the SA.	Substantial Compliance

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	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	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. 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. Since the last review the Facility had laminated posters and/or used 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 were reviewed by the Monitoring Team for July and August and reported 100% compliance. The Monitoring Team has determined that the DSSLC was in substantial compliance with this component of the SA.	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 does not concur. To be in substantial compliance with this component of the SA there should be evidence that at least all allegations of physical abuse receive a law enforcement referral. Seven of the 14 allegation investigations completed by DFPS (Sample D.1) contained allegations of physical abuse. Two investigation reports (29%) did not include documentation that a law enforcement referral had occurred. This was the case for investigations 39406527 and 39999827. In each case there was no entry in the section labeled "date and time of law enforcement notification." All allegations of physical abuse, if substantiated, likely represent some form of assault or battery that could result in the perpetrator being criminally charged. Therefore, it is important that all allegations of physical abuse receive law enforcement referral. 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.	Noncompliance

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	(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. 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 that was displayed prominently throughout the Facility. In talking to two individuals at the Self-Advocacy meeting the Monitoring Team, through conversation, determined that at least these two individuals could describe what they would do if someone hurt them, or they had a problem with which they needed help. Neither indicated they understood the concept of retaliation. Based on an interview of five staff responsible for the provision of supports to individuals, all were clear in their understanding that retaliation was not tolerated by the facility administration and if it occurred, facility administrators would take action. The Monitoring Team interviewed an OIG investigator and two DFPS investigator all of whom had no direct knowledge of specific retaliation that was alleged or had occurred. All were confident that if it did occur Facility administration would respond appropriately. Based on a review of investigation records (Sample D.1 and Sample D.2), there were no concerns noted related to potential 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 no allegations of retaliation have been made. The Monitoring Team has determined that the DSSLC was in substantial compliance with this component of the SA.	Substantial compliance
	(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 substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. The Facility had a regular audit process in place capable of detecting instances of unreported injuries. The auditor reviewed the individual records, especially nursing	Substantial Compliance

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		notes and progress notes, to identify entries that should have resulted in an injury report. If an injury report was found the auditor determined if the entries were consistent with notes found in the record. If no injury report was found, or if data entries were inconsistent, the auditor followed-up to insure an injury report, although late, was generated with appropriate backup documentation. The auditor also ensured inconsistent data elements are reconciled. Results of these audits were reviewed by the Monitoring Team for July and August. The Monitoring Team was able to confirm the audit process occurs as designed, and that as occasional issues are identified through this process, corrective actions were taken and were documented in the audit file. The Monitoring Team has determined that the DSSLC was in substantial compliance with this component of the SA.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:	In its Plan of Improvement (POI) the DSSLC reported substantial compliance with this provision of the Settlement Agreement. The Monitoring Team does not concur. This provision of the SA includes ten components (a-j). All must be in substantial compliance in order for the provision to be in SA. The Monitoring Team determined that two components rated as in substantial compliance by the DSSLC were not.	
	(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 concurs. The Monitoring Team review of facility policy found it described the conduct of 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.	Substantial Compliance

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		Finally, the Facility policy required that investigators be outside of the direct line of supervision of alleged perpetrators. The Monitoring Team reviewed material used by DFPS in training its investigators. The required class "MH&MR Investigations ILSD" consisted of the following modules: 1. Introduction and History of DFPS, APS, DADS, and DSHS 2. Laws, Rules, & Policies Governing APS MH&MR Investigations 3. Dynamics of Abuse, Neglect, and Exploitation 4. Psychiatric Terms 5. Client Rights 6. Prevention and Management of Aggressive Behavior 7. Evidence Collection 8. Basic Interviewing 9. Interviewing Persons with Developmental Disabilities 10. MH&MR IMPACT Technical Guide 11. Analysis of Evidence 12. Effective Writing 13. Disposition of Cases The required class MH&MR Investigations ILASD included the following modules: 1. Cross-Cultural Interviewing 2. Strengthening the Written Report 3. Deception and Confrontation of Deception 4. Time and Stress Management In reviewing the materials associated with these modules, and in consideration that DFPS case investigations reviewed by the Monitoring Team were generally thorough and comprehensive and case reports were generally well written, the Monitoring Team is of the opinion that this training was competency-based and 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 additional training in working with people with developmental disabilities. DFPS had seven investigators assigned to work DSSLC cases. The training records for these investigators were reviewed. All seven completed the requirements for investigations training DSSLC had eight staff designated as investigators. The training records for these staff	

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		were reviewed. All eight had completed the required training. 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. The Monitoring Team has determined that the DSSLC was in substantial compliance with this component of the SA.	
	(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 concurs. The Monitoring Team did not find any instances of lack of cooperation in its review of the 14 DFPS investigations in Sample D.1. Additionally, the Monitoring Team interviewed two DFPS investigators and an OIG investigator asking specific questions about facility cooperation All reported exceptional levels of cooperation by facility staff. DSSLC policy CMGMT 01B Incident Management (7/1/11) would be expected to address this SA requirement. The Monitoring Team did not identify language in the policy that addresses this subject. 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. The Facility should consider such changes when it revises this policy. The Monitoring Team was able to substantiate compliance based on its review of investigation documentation and interviews with DFPS and OIG investigators.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any	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	Substantial Compliance

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	investigations completed by law enforcement agencies so as not to interfere with such investigations.	Monitoring Team concurs. A 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 14 investigations completed by DFPS and the Facility in Sample D.1, no evidence of interference by one agency or the other was identified. Of the five 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. The Monitoring Team has determined that the DSSLC was in substantial compliance with this component of the SA.	
	(d) Provide for the safeguarding of evidence.	In its Plan of Improvement (POI) the DSSLC reported substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. Exhibit B to policy CMGMT 01B Incident Management (7/1/11) provides specific guidelines for safeguarding evidence. While on site, the Monitoring Team observed the area the Facility uses for safeguarding evidence 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. The Monitoring Team has determined that the DSSLC was in substantial compliance with this component of the SA.	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 does not concur.	Noncompliance

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	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.	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. The Monitoring Team was provided with an undated document titled "Commencement of DFPS Investigation.". Facility staff reported the procedures outlined in this document went into effect 8/1/11. The Monitoring Team expects substantive investigatory activity to commence within 24 hours of an incident being reported. These new procedures did not require DFPS presence at the Facility within 24 hours of an incident being reported. They did require that enough information be obtained from the Facility to enable DFPS to "develop an initial plan for the investigation" within 24 hours. These procedures required DFPS to instruct the Facility to "protect evidence." Evidence includes testimonial evidence from witnesses and the alleged perpetrators. Often, this is the primary evidence used in DFPS investigations and used to reach investigation conclusions. For the Facility to protect this evidence measures would need to be taken, including in some cases the need to isolate staff witnesses from one another in order to not potentially contaminate testimony until witness interviews have occurred (which is the primary reason that DFPS should begin interviewing staff as soon after the reported incident as possible). DFPS case reports should document the specific actions that the Facility was directed to take, and took, to protect evidence, including the integrity of testimonial evidence provided by witnesses, potential witnesses, and alleged perpetrators. 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: Two of 14 (14%) commenced within 24 hours. These were investigations 40138607 (7/12/11) and 40230446 (8/9/11). 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. Eight of the 14 DFPS investigations in Sample D.1 occurred after 8/1/11. Review files prepared by the Facility to document compliance with SA requirements did not contain	

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		sufficient information to determine if the new commencement process had occurred as described in the previously referenced document. Five investigations (39887247, 40236905, 40227051, 40237234 and 40225390) reported that the initial face-to-face interview occurred within 24 hours; however, upon closer examination the Monitoring Team determined these initial interviews were of individuals who were nonverbal or otherwise unable to provide the investigator with any useful information. Staff interviews, in each case, did not begin within 24 hours and in some cases days later. For example, case 40236905 was reported to DFPS on 8/14/11 and the first staff interview was on 8/26/11. In seven instances (39406527, 39999827, 40016528, 40210400, 40212629, 40232104, and 40232350) an initial face-to-face interview of any kind did not occur within 24 hours. Documentation of activity undertaken prior to onsite interviews did not reflect other substantive investigatory activity, except that some relevant documents were reviewed within 24 hours for investigations 40016528 and 40232104 that constituted substantive activity. It should be noted that DFPS commencement policy as revised and implemented 8/1/11 requires additional documentation of substantive work conducted during the first 24 hours; investigations 39406527, 39999827, 40210400, and 40212629 occurred prior to 8/1/2011. Eleven of the 14 investigations (79%) were completed within 10 calendar days of the report of the incident. The three that were not were 40225390, 40236905, and 40016528. The documentation files prepared by the Facility for these three investigations did not include any evidence to validate that an extension request was made by the DFPS investigator to their supervisor explaining the extraordinary circumstances and that such a request was approved in writing. Fourteen (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 (100%) 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:	

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		Five of five (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 five (100%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. Five of five (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. In all five of the investigations reviewed, recommendations for corrective action were included. In all five of the investigations (100%), the recommendations appeared adequate to address the findings of the investigation. To achieve compliance with this component of the SA substantive investigatory activity must begin with 24 hours of a report of an incident. This investigatory activity would often occur at the Facility and include interviews with witnesses, but it must include clear documentation of initiation of substantive investigatory tasks.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material	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. The contents of the investigation reports reviewed were sufficient to provide a clear basis for its conclusion. Most reports utilized a standardized format that sets forth explicitly and separately: • 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.	Noncompliance

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	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 14 of 14 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 14 (100%), each serious incident or allegations of wrongdoing; o In 14 (100%), the name(s) of all witnesses; o In 14 (100%), the name(s) of all alleged victims and perpetrators; o In 14 (100%), the names of all persons interviewed during the investigation; o In 14 (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 14 (100%), all documents reviewed during the investigation; o In 14 (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 14 (100%), the investigator's findings; and o In 14 (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: • In five of five investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately o In five (100%), each serious incident or allegations of wrongdoing. o In none (0%), the name(s) of all witnesses. Section 5 of the UIR records the names of "staff on duty at the location or suspected location of the incident." This does not necessarily include all witnesses, for example, another individual, a visiting family member, a dietary worker delivering food, or a nurse or administrator making rounds are all potential witnesses. Additionally, the instructions that accompany the UIR state "do not routinely list all staff on the shift/home if they do not have relevant knowledge or investigative value." It is unlikely a determination as to whether a staff person "has relevant knowledge or	

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		investigative value" can occur without at least obtaining a witness statement, or making a clear determination as to why a witness statement was not taken, for example, a staff person is listed on a duty roster but was off campus with a group of Individuals at an activity, or, was away from the home attending a training class.. The Monitoring Team cannot determine whether all five investigations of serious injuries identified the names of all witnesses. o In six (100%), the name(s) of all alleged victims and perpetrators. o In none (0%), the names of all persons interviewed during the investigation. Investigation files did not contain the names of persons interviewed. Witness statements were present and Facility staff reported that facility investigators interview the staff writing the statement to validate their correctness; however, there was not any documentation of an interview occurring such as date/time and who conducted the interview. o In none (0%), 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. The Facility needs to establish work processes that establish the method by which all witnesses are identified, how a determination is made as to which witnesses are interviewed, and how interviews are conducted and documented.	
	(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. This policy 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	Noncompliance

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		the DFPS investigations and the Facility investigations are discussed separately. DFPS Investigations The following summarizes the results of the review of DFPS investigations: Fourteen of 14 (100%) case files reviewed contained evidence that the DFPS supervisor had conducted a review of the investigation report. In all 14 (100%) 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. Additionally, the Facility has established a "Review Authority" to review each DFPS investigative report. This group consists of the Facility Director, Assistant Director of Programs, Director of Residential Programs, the Director of Incident Management, and the Incident Management Coordinator. The purpose of this group reviewing each DFPS case report is to ensure thorough review by executive team members. The Monitoring Team observed a meeting of the Facility Review Authority. This group reviews each DFPS investigative report 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 identified in this review are expected to be addressed promptly. Facility Investigations The following summarizes the results of the review of Facility investigations: • In all five investigation files reviewed there was evidence that the supervisor had conducted a review of the investigation report. • In all five, as described in Section D.3.f above there was insufficient evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. The Monitoring Team has determined that the DSSLC was not yet in compliance with this component of the SA.	
	(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. The Monitoring Team identified three separate review forms used in documenting investigation review in case files. These were: 1. DSSLC Incident Management Team Review for Incident Investigations and Related Follow-up Action. This form documents review of each DFPS	Substantial Compliance

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		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. It appeared this form is used to document review by the Review Authority. 2. SSLC Incident Management Team Review of DFPS Investigations. It was not clear to the Monitoring Team as to what circumstances would result in this form being used as opposed to the form described above. 3. Investigation Review/Approval Form. This form is apparently used to validate incident management supervisory review of UIRs. While not necessary to establish compliance with this component of the SA, the Facility may want to retitle these forms, and their content requirements, to more clearly describe their intended use. The information contained in these forms served to document compliance with this component of the SA.	
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	In its Plan of Improvement (POI) the DSSLC reported substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. DSSLC policy CMGMT 01B Incident Management (7/1/11) 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 Monitoring Team asked for source documentation associated with recommendations noted in several UIRs. In each case the Facility was able to produce documentation from investigation files. This documentation confirmed corrective actions were implemented promptly and thoroughly. Less clear was the degree to which planned actions were designed to "prevent recurrence" and that the outcomes expected from corrective actions were discussed, identified, or otherwise made a part of the corrective action planning process associated with investigation follow-up. For example, a typical action might be retraining a staff person or a group of staff. Documentation would validate that the training occurred; however, there did not appear to be any work effort directed at validating that the training prevented recurrence. This should likely be appropriately included in data analysis occurring within the QA department of the Facility. Case files reviewed by the Monitoring Team included copies of all relevant disciplinary action taken in response to investigation findings. The Monitoring Team has determined that the DSSLC was in substantial compliance with	Substantial Compliance

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		this component of the SA.	
	(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. 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. If they do not they can easily access this information from the Facility. The Monitoring Team has determined that the DSSLC was in substantial compliance with this component of the SA.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	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. In the last review the Monitoring Team noted that it 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 presentation of data in the DSSLC Allegations Trend Report (8/31/11) did not delineate DFPS cases by type (i.e. type of abuse and type of neglect) in the monthly numerical counts displayed in the first four pages of the report. A graph was presented on page five reporting types of allegations over a rolling 12 month period. The numerical counts should also reflect the type of allegation as does the graph. This would enable Facility staff to review trends with more clarity as the graph contains potentially six intersecting data lines. Additionally, the graph on page 12 which reports case disposition does not delineate by type of case. Finally, the trend report does not provide for longitudinal presentation of trend data by any subcategories, such as allegations by home, by shift, etc. DSSLC needs to modify its Trend Analysis Report to reflect specific data elements on type	Noncompliance

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		of allegations and disposition by type not just for the current month but over time as occurs with other data elements in the report. Some of these observations were made by the Monitoring Team at the last review. While some effort had been made to improve tracking and trending data more is needed. From the data in the Trend Reports the Monitoring Team was able to make the following observations: The number of DFPS cases had increased slightly. In the five months since the last review the DSSLC averaged 13 cases per month. In the prior five months the Facility averaged 12 cases per month. This is an 8% increase. The number of serious injuries had decreased. In the five months since the last review the DSSLC averaged 20 serious injuries per month. In the prior five months the Facility averaged 23 per month. This is a 15% decrease. The number of non-serious injuries had increased significantly. In the five months since the last review the DSSLC averaged 153 non- serious injuries per month. In the prior five months the Facility averaged 85 per month. This is an 80% increase. 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, including Section D. 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.	
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	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. 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	Substantial Compliance

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	factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	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 and 12 volunteers 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. Facility policy requires employees to self-report encounters with law enforcement that may impact their continued eligibility for employment. The State also provided similar information to the Facility as cross-matches routinely occur between state employee records and background check databases. This process identifies employees who did not self-report law enforcement encounters. As a result of this process, since the last review, two employees at the DSSLC were identified as not having self-reported dischargeable offenses to the Facility. Both were immediately placed on emergency leave and subsequently discharged by the Facility. The Monitoring Team has determined that the DSSLC was in substantial compliance with this component of the SA.	

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

1. Fully and consistently implement DSSLC Policy CMGMT-01B Protection from Harm – Incident Management 7/1/11(Provisions D.2.a, D.2.g, D.3.e, and D.3.f).
2. Ensure Facility investigations of serious incidents include all components necessary to demonstrate compliance with SectionD.3.f of the SA, including documenting the rationale for making a determination as to why certain witness statements were not taken (Provision D.3.f).
3. Revise the Facility Trend 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. Report both numerical counts and graphs (Provision D.4).
4. Revise the Facility Trend Report to report additional data elements longitudinally (Provision D.4).

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 9/7/11 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 QA Plan 9/20/11 6. DSSLC Policy C&C-02 Quality Assurance/Quality Improvement Council 9/6/11 7. Quality Assurance/Quality Improvement Council Meeting: Data Analysis Report 7/21/11, 8/18/11, and 9/20/11 8. Quality Assurance/Quality Improvement Council meeting minutes 7/21/11 and 8/18/11 9. Monitoring tools and guidelines for each provision of the SA (various dates) 10. Allegations Trend Report 8/31/11 11. Unusual Incidents Trend Report 8/31/11 12. Restraint Trend Report 8/31/11 **People Interviewed:** 1. Lori Powell, Director of Quality Assurance 2. Deb Salsman, Director of Incident Management **Meetings Attended/Observations:** 12. Incident Management Team (IMRT) 9/19/11 13. Restraint Reduction Committee 9/22/11 14. Quality Assurance/Quality Improvement Council (QA/QI Council) meeting 9/20/11 1.
	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 the monitoring/audit system is maturing in a satisfactory manner and that a Corrective Action Plan (CAP) tracking system was established in July. 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 did not appear to have any formal process from which it determined compliance ratings for this section of the SA. The Facility continued 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 had been formalized.
	Summary of Monitor's Assessment: The Facility continued to make progress in the development of a QA process that can measure ongoing

	compliance with the requirements of the SA. A comprehensive Quality Assurance Plan had been formalized noting for each section of the SA the monitoring tools in use, the frequency of monitoring, and responsibilities of various staff who must implement the plan. Compliance reports were routinely prepared and presented to the QA/QI Council for review and discussion. The amount of substantive discussion at the QA/QI Council was much improved compared to that observed at the last review. Compliance reports were based on data developed from the use of the monitoring tools over time. A database for the monitoring data was used to facilitate analysis. The Facility had begun a more formal process for inter-rater reliability from that observed at the last review. As the Facility expands inter-rater reliability efforts they will need to include methods to evaluate the effectiveness of the process. The Facility needs to improve the organization of its tracking and trending to ensure the Facility can track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports. Data presented in reports associated with the SA monitoring tools was improved since the last review. More data items reported longitudinal trends which enabled the QA/QI Council to engage in more substantive discussion at their meeting. The Monitoring Team believes a Quality Assurance and Corrective Action Planning process should include two different sets of activities and strategies for outcomes: 1. Development of specific actions necessary to correct specific problems discovered through monitoring and auditing conducted by residential units and facility departments, and by Program Auditors in the QA Department. 2. Development of broader strategic action plans to correct systemic problems identified through the analysis of data collected over time from a variety of sources, such as: the results of monitoring/auditing referenced above; tracking and trending data described in E1; regulatory reports (CMS 2567's); reports (anecdotal and written) coming from DADS subject matter experts, outside consultants, DFPS, OIG, and others; and, data collected from self-advocacy group meetings, family member meetings, and other stakeholders. At the time of the review, the QA activity in place at DSSLC consisted largely of administrative steps directed at this first strategy. Activity directed at the second strategy was limited and needs to expand. The Monitoring Team suggested to the DSSLC QA Director that the Facility may want to consider coding CAPs in a way that allows CAPs that target similar types of problems to be summarized in separate reports. This could facilitate a process where CAP data associated with similar types of problems could be reviewed looking for systemic issues needed attention, and, to determine if previously completed CAP activity has met the desired outcome of remedying or reducing the problems originally identified.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	In 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 database necessary to achieve compliance with this provision had not yet been fully developed although improvements were noted from what was observed at the last review. The Facility continued to make progress in the development of a QA process that was intended to measure ongoing compliance with the requirements of the SA. A Quality Assurance Plan had been formalized since the last review. These compliance reports are based on data reported from various staff that used the monitoring tools. A data base for the monitoring data had been developed and has been in place long enough that at least for some areas being monitored analysis and trends are beginning to be identified and presented to the QA/QI Council. The Facility had established workgroups for each section of the SA. They are to continue developing operational plans to achieve SA compliance. They were also responsible for the development of a QA component for each provision. The DSSLC had a Quality Assurance/Quality Improvement Council in place. 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 included topics such as: overall fill (staff) rates, overall turnover (staff) rates, training compliance, deaths, aspiration related deaths, 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, and community placements. These were all good metrics from which organizational performance (and SA compliance) can be measured. Reports generated from Monitoring Tool data were presented at the QA/QI Council meeting and there was substantive problem solving oriented discussion in some areas, especially when reviewing data associated with the key indicators. Some key indicators addressed some elements of the SA. The discussion of data associated with SA provisions (other than that which intersected with key indicators data and discussion) was primarily information sharing with limited dialogue addressing program or process improvements necessary to achieve compliance with the SA. This may be because the Facility appears to have other mechanisms to engage in problem solving such as the	Noncompliance

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		workgroups previously mentioned. Other committees also address certain SA compliance issues, for example, the Restraint Reduction Committee and the Infection Control Committee. The Facility had begun a more formal process for inter-rater reliability from that observed at the last review. Most monitoring tools are administered by unit/department staff and by QA staff. As a result a process for inter-rater reliability can occur. The Facility reported that in one area this process has occurred and led to improved inter-rater reliability. The example provided to the Monitoring Team was the Section C Restraints monitoring tool. Behavioral services staff use the tool in measuring compliance with required activity and documentation associated with Section C. Independently, QA staff use the same tool for the same restraint. The behavior analyst, who is the Section C lead, reviews the two monitoring tools, identifies discrepancies, and meets with the staff that completed the tools to review and discuss the discrepancies. This is a good process; however, documentation associated with the process, and whether it was leading to fewer discrepancies (i.e. improved inter-rater reliability) were not apparent. As the Facility expands inter-rater reliability efforts they should include methods to evaluate the effectiveness of the process. The Monitoring Team believes a Quality Assurance and Corrective Action Planning process should include two different sets of activities and strategies for outcomes: 1. Development of specific actions necessary to correct specific problems discovered through monitoring and auditing conducted by residential units and facility departments, and by Program Auditors in the QA Department. 2. Development of broader strategic action plans to correct systemic problems identified through the analysis of data collected over time from a variety of sources, such as: the results of monitoring/auditing referenced above; tracking and trending data described in E1; regulatory reports (CMS 2567's); reports (anecdotal and written) coming from DADS subject matter experts, outside consultants, DFPS, OIG, and others; and, data collected from self-advocacy group meetings, family member meetings, and other stakeholders. The QA activity in place at DSSLC consisted largely of administrative steps directed at this first strategy. Activity directed at the second strategy was limited and needs to expand. The Monitoring Team suggested to the DSSLC QA Director that the Facility may want to consider coding CAPs in a way that allows CAPs that target similar types of problems to be summarized in separate reports. This could facilitate a process where CAP data associated with similar types of problems could be reviewed looking for systemic issues needed attention, and, to determine if previously completed CAP activity has met the desired outcome of remedying or reducing the problems originally identified.	

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		Trending of allegations of abuse and neglect, unusual incidents, and restraints provide examples of the current status of the Facility's processes to track and trend information. DSSLC produced a monthly Allegations Trend Report, a monthly Unusual Incidents Trend Report, and a monthly Restraint Trend Analysis. The Facility also produced a multitude of reports related to the use of SA Monitoring Tools. The Trend Reports contained most of the required data elements for the topics they cover. Most data were reported for only the current report month. Only a limited data set was displayed for a rolling 12 month period, limiting its utility in trend analysis. Some additional longitudinal tracking and trending had been implemented since the last review. For example, the report now contains a line graph showing confirmed vs. unconfirmed DFPS cases. While this is a step in the right direction even this graph does not correlate to the range of dispositions DFPS uses in its investigation reports. For example, some dispositions are classified as "unsubstantiated." which is a different disposition than unconfirmed. The Facility needs to improve the organization of its tracking and trending to ensure the Facility can track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports. Current month data on the allegations 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 presents necessary data for the current month (except DFPS activity is not delineated); 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. Some elements of these data were separately presented to the QA/QI Council trended over time indicating the Facility understands the necessity of doing so to facilitate effective analysis.. The other trend reports generated by the DSSLC were similarly deficient in presenting rolling 12-month data, which limited 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 reports associated with the SA monitoring tools was improved since the last review. More data items reported longitudinal trends, which enabled the QA/QI Council to engage in more substantive discussion at their meeting.	

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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. The QA director presented the Monitoring Team with a set of SA monitoring tools that corresponded to each provisions of the Settlement Agreement except section L – medical care. The State had initiated a separate process of peer review to measure physician practices against the expected standard of care. Each monitoring 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. Most provisions had one tool; there were 12 for nursing care and three for most integrated setting practices. 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. From interview and documentation review, 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 did 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. Much of the CAP documentation provided to the Monitoring Team was not dated, did not have an identifying title on it, and did not indicate its purpose. In nearly every instance, explanation by staff was necessary for the Monitoring Team to understand the content in what was presented as a CAP report. This work activity, which occurs throughout the organization, needs improved organization and coordination. Most of the data reviewed by the QA/QI Council comes from the monitoring tools that are used for each provision of the SA. While there was some evidence that corrective action plans were initiated when monitoring discovered specific deficient practices, there was not yet evidence that monitoring results were compiled and organized in such a manner that identification of systemic issues requiring a broader and more thorough corrective action plan was an outcome of the QA activity. There are still several improvements	Noncompliance

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		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. Expanding the inter-rater reliability process discussed in Provision E.1 should help in this regard. 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 an effective 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, and 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 to identify an array of potential systemic issues requiring attention. While improvement in this was noted from that observed at the last review the Monitoring Team views this as a continuing work in progress.	
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. The CAP system observed during this review was insufficiently organized to provide the Monitoring Team with assurance that CAPs were disseminated to all parties responsible for their implementation. The process needs to define and identify "all parties" at the point a CAP is developed. The Monitoring Team was unable to find specific guidance in DSSLC policy's that would clarify this process. CAPs identify a "responsible person" but it is not clear if that is sufficient to validate that a CAP had been disseminated to "all parties" as required by the SA. Addressing this is policy would help in this regard.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	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 Facility was asked if the database used to track CAPs could produce a list of all open CAPs and all closed CAPs, and, if these reports could be produced by subject matter or	Noncompliance

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		other delineations such as the Department assigned responsibility for implementation. At the time of review tracking of this nature could not be done. Additionally, the Monitoring Team was unable to identify any work processes that evaluated whether a CAP met the desired outcome of remedying or reducing the problems originally requiring a CAP, particularly with respect to systemic issues. The Monitoring Team believes a Quality Assurance and Corrective Action Planning process should include two different sets of activities and strategies for outcomes: 1. Development of specific actions necessary to correct specific problems discovered through monitoring and auditing conducted by residential units and facility departments, and by Program Auditors in the QA Department. 2. Development of broader strategic action plans to correct systemic problems identified through the analysis of data collected over time from a variety of sources, such as: the results of monitoring/auditing referenced above; tracking and trending data described in E1; regulatory reports (CMS 2567's); reports (anecdotal and written) coming from DADS subject matter experts, outside consultants, DFPS, OIG, and others; and, data collected from self-advocacy group meetings, family member meetings, and other stakeholders. The QA activity in place at DSSLC consisted largely of administrative steps directed at this first strategy. Activity directed at the second strategy was limited and needs to expand. The Monitoring Team suggested to the DSSLC QA Director that the Facility may want to consider coding CAPs in a way that allows CAPs that target similar types of problems to be summarized in separate reports. This could facilitate a process where CAP data associated with similar types of problems could be reviewed looking for systemic issues needed attention, and, to determine if previously completed CAP activity has met the desired outcome of remedying or reducing the problems originally identified.	
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. The QA activity in place at DSSLC consisted largely of administrative steps directed at individual issues identified through monitoring/auditing discussed in Provision E.1. Activity directed at systemic issues was limited and needs to expand. For example, there was no evidence of a mechanism to track whether similar problems requiring similar CAPs reoccurred, indicating a need for a systemic response. The Monitoring Team suggested to the DSSLC QA Director that the Facility may want to consider coding CAPS	Noncompliance

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		in a way that allows CAPS that target similar types of problems to be summarized in separate reports. This could facilitate a process where CAP data associated with similar types of problems could be reviewed looking for systemic issues needed attention, and, to determine if previously completed CAP activity has met the desired outcome of remedying or reducing the problems originally identified, and, if not have been modified and subsequently evaluated for effectiveness. Furthermore, the Monitoring Team did not identify any process used regularly by the Facility to track effect of CAPs and determine whether they need to be revised. To achieve compliance with this provision, the Monitoring Team will need to provide evidence that effectiveness of CAPs is monitored, and that CAPs are revised as needed.	

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

1. Expand the data reported in Trend Reports to display more longitudinal data and to appropriately delineate subcategories, such as type of abuse (Provision E.1).
2. 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 (Provision E.1).
3. Develop a system of "weighting" data items on monitoring tools, where appropriate (Provision E.1).
4. 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 (Provision E.1).
5. Develop a methodology to define and identify staff who should receive CAPs (Provision E.3).
6. Organize information related to CAPS in such a way data can be used to help identify systemic issues (Provision E.2).
7. Organize information related to CAPS so that effectiveness can be measured and CAPs can be modified as necessary (Provisions E.4 and E.5).

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 9/7/11 2. DSSLC Section F Presentation Book, undated 3. DADS Policy 004 Personal Support Plan Instructions , dated 7/30/10 4. DSSLC Policy CMGT-12.01 Personal Support Planning Process, dated 1/3/11 5. DSSLC Policy CMGT-12.01 Personal Support Planning Process Pilot Project Personal Focus Assessment and Facilitation, dated 8/5/11 6. PSPs for Individuals ##46, #269, #334, #546, #566, #627, and #73 7. Record Reviews for Sample 1 in Section O: Individuals #3, #20, #117, #211, #291, #336, #366, #504, #511, #519, #551 and #599 8. 30-Day PSP, assessments and Training Documentation Reports (TDR) for Individual #119 9. PSP Delinquency Tracking, undated 10. PSP Assessments Tracking, dated 7/30/11 11. PSP Assessments in the O Drive for Individuals #68, #187, #373, $599, #633, #674, and #705 12. PSP Attendance Tracking, dated 8/31/11 13. Personal Focus Interviews (PFI) for Individuals #33, #61, #80, #102, #164, #373, and #549 14. Section F Settlement Agreement Monitoring Tools for Individuals #205, #271, #299, #312, #367, #510, #541, #656, #715, #734, and #799 15. QA/QI Council Meeting: Data Analysis Report for Section F, dated August 18, 2011 **Persons Interviewed:** 1. Lori Powell, Director of Quality Assurance 2. Andy Maher, Director of Consumer and Family Relations (CFR) 3. Frank Padia, Director of Program Coordination 4. Randy Spence, Director of Behavioral Services 5. Ken Horstman, Director of Residential Services 6. Berry Sudderth, QDDP Auditor/PFI Interviewer 7. Linda Ford, Director of Active Treatment 8. Trent Lewis, Life Skills Instructor 9. QDDPs for Individuals #61, #164, #269, #373, and #384 10. Five DCPs at various homes 11. DCPs at 507A **Meetings Attended/Observations:** 1. PSPs for Individuals #61, #80, and #373 2. Personal Focus Interview (PFI) meeting for Individual #341 3. CLDP Meeting for Individual #384 4. At Risk Team Meetings for Individuals #102 and #306 5. Human Rights Committee (HRC) Meeting

	Facility Self-Assessment: The Monitoring Team reviewed the DSSLC POI. DSSLC reported it was not in compliance with any of the provisions, or the components with each provision, of this section of the SA. The Monitoring Team concurred. With a few exceptions, the current POI simply reported on actions taken, rather than evaluating whether the actions taken are producing the desired outcomes, and why or why not. The POI did not provide many details as to the Facility's self-assessment processes, but rather listed actions the Facility had taken since the last visit and, in some cases, provided a list of Action Steps and completion status. The Facility should consider how it may more fully use its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes. **Provision F1:** The Facility indicated it was not in compliance with this provision. Actions that had been taken to enhance the functioning of the interdisciplinary teams included QDDP training in PSP facilitation (Q Construction) and designating four facilitators certified as competent through the Q Construction process to guide all PSP development. The Facility also reports initiating a pilot process for completing the Personal Focus Assessment as a Personal Focus Interview (PFI) and merging the Workgroups for Sections F, T and U. To assess the results of these processes, the Facility also reported it had begun tracking PSP attendance by disciplines through a statewide database, completing random record audits using the Section F monitoring tools, and tracking timely submission of PSP assessments. **Provision F2:** The Facility indicated it was not in compliance with this provision. Actions that had been taken to enhance the functioning of the interdisciplinary teams included many of the same steps as reported for Provision F1. Additional actions to enhance the implementation of the PSPs included the piloting of the Murdoch System for development of skill acquisition programs, implementation of a "Tools for Effective Training" curriculum for active treatment and other residential staff, and implementation of competency based training on the PSP in new employee orientation. The Facility also reported taking action to assess results through use of the Section F monitoring tools and tracking timely submission of PSP assessments.
	Summary of Monitor's Assessment: DSSLC indicated it was not in compliance with any of the components for these provisions and the Monitoring Team concurred. The assessment which follows represents a compilation and synthesis of the interdisciplinary findings of the Monitoring Team. **Provision F1:** The Facility continued to implement the "Supporting Visions" PSP process, which was intended to reinforce the concept that planning is intended to support the individuals' vision for the future for him/herself. The Monitoring Team was pleased to see additional training, coaching and mentoring being provided to the QMRPs and PSTs. These initiatives, which also included the Q-Construction facilitation skills training and follow-up as well as a dedicated external consultation on the development of quality PSPs, were recent developments, but demonstrated some promise for enhancing the PSPs at DSSLC. The Facility was also experimenting with some innovative approaches, including a pilot process for completing the Personal Focus Assessment as a Personal Focus Interview (PFI), and using four key staff,

	certified as competent through the Q Construction training, to act as facilitators for PSP meetings, while continuing to mentor the QDDPs. The Workgroups for Sections F, T and U had also been merged in recognition of their common key focus of person-centered PSP development. The Monitoring Team commends the Facility for continuing to seek ways to enhance the PSP process. There was some evidence of positive change noted, in that the Monitoring Team attended one PSP that offered the best example of an integrated and interdisciplinary planning process the Team had witnessed over the past two years. Overall, however, the new PSP format, and process, was still meeting with limited success specific to the requirements of this section of the SA. No meaningful preparation was provided to ensure the PFI and/or PSP processes were conducted in a manner that facilitated real participation by the individuals. PST members sometimes came to planning meetings without a basic knowledge or awareness of an individual's current status or needs. In addition, PSTs often failed to conduct comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs. The Monitoring Team found this to be a pervasive issue at the Facility that will need immediate and sustained attention to remediate. **Provision F2:** The Monitoring Team found there were some examples of improved integration observed in planning meetings and record reviews. Overall, however, PSPs lacked many of the criteria specified in the SA for this Provision. For example, PSPs did not consistently specify 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 and meet identified needs, nor did barriers to living in the most integrated setting always lead to goals, objectives, or service strategies. PSP strategies did not reflect encouragement of community participation in any meaningful or purposeful manner; however, the Active Treatment Department had begun to attempt to create meaning and purpose for community integration activities by correlating community outings with other objectives for specific individuals, and providing varying level of instructions for staff as to training to be implemented during the activities. This was a new endeavor, which was to be commended for its intent, but will require significantly more organization if it is to be successful. The PSTs should take the primary responsibility for specifying the purposes for community activities, including, for example, how these activities support preferences and personal goals, training needs for functional skills, and increasing community awareness.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that	This provision was found to be not in compliance. DSSLC had recently begun to use four Facilitators to guide the PSTs in the development of the PSP. These individuals had	Noncompliance

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	members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	completed the Q Facilitator training and been certified as competent to act in this capacity. In the PSPs observed during this monitoring visit, the Facilitators exhibited varying levels of competency. The Monitoring Team commends the initiative of the Facility towards ensuring effective PSP meetings and planning and looked forward to seeing the longer term results at the next site visit. The assigned QDDP remained responsible for monitoring and revising treatments, services, and supports. The QDDP did not consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed as described below.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	This provision was found to be not in compliance. During the last review it was noted that the DSSLC maintained a PSP Attendance Tracking log which identified, by discipline, staff that attend PSP and PSPA meetings. The Facility no longer maintains this log and the tracking system now in place is not specific to each individual. As a result, the Monitoring Team cannot determine, for an individual, if appropriate PST members were in attendance at PSP and PSPA meetings other than by reviewing each PSP and PSPA. A tracking log was presented to the Monitoring Team displaying "Monthly Attendance by Discipline (PSPs only) for the month of August, 2011. From this log it appears 57 PSPs were held. The QMRP was present at 51, nursing at 52, psychologist at 32, and direct contact professional at 38. These data are very difficult to understand and interpret, not just by the Monitoring Team, but also by staff responsible for overseeing the PSP process. The tracking log presented at the last review was much more useful to the Facility as well as to the Monitoring Team. Certain disciplines appeared to have significantly lower rates of participation, and this, in turn, appeared in some instances to be related to a relatively low number of staff in that discipline. For example, while SLP presence during PSPs and PSTs had improved since the previous site visit, SLPs remained absent in many of the facets of care required by their profession. Please refer to Section R for more detail. Meaningful participation by individuals themselves was very limited. Individuals with intellectual disabilities 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 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 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 QDDPs to better facilitate this process may be found at: http://www.ilr.cornell.edu/edi/pcp/courses.html.	Noncompliance

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		Such a planning process might include, for instance, many opportunities across the year for staff to assist each individual to create pictorial representations of the things that matter to them. Using photographs, drawings, pictures from magazines and books, for example, each individual could develop a poster portfolio of such things as "Important People in My Life," Things I Want to Do," Places I Want to Go," What My Ideal Home Looks Like," "Things I am Good At," etc. These posters could then be placed on the walls to begin the PFI meeting, making them much more meaningful to the individual, simply by having the visual cues. It would also provide a more meaningful way for the PST to explore the PFI areas with the individual. The portfolio could then be revised for the PSP meeting based on the PFI results. This would make the PSP a much more comprehensible and positive experience.	
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.	This provision was found to be not in compliance. The Monitoring Team found an overall lack of rigor, and at times, personal accountability in the assessment processes at DSSLC. This is particularly troubling since careful assessments must lay the groundwork for all protections, supports and services to be provided. The Monitoring Team found this to be a pervasive issue that merits immediate attention on the part of the Facility. Assessments were not routinely completed on a timely basis. At the previous review the Monitoring Team was provided with an assessment tracking log by individual. From this log it was possible to determine, by individual, whether an assessment was completed and filed within the timeframe required by facility policy, and, if not, when the assessment was completed and available to the PST. This log had been discontinued. In its place is a document titled "Annual Assessments Filed 10 Days Prior to PST By Assessment." This document apparently tracks aggregate data. The report for July reports a compliance rate of 50% for speech assessments, 26% for psychological assessments, 22% for OT/PT assessments, 36% for nursing assessments, 35% for physician assessments, and 68% for dental assessments. These data may be useful in looking at overall organizational performance but is of limited utility in measuring compliance with this component of the SA. Nevertheless, the data provided by the Facility confirm that assessments were not routinely completed timely. The Monitoring Team reviewed the available PSP assessments for seven individuals who had PSP meetings during the week of the site visits or PSP meetings scheduled to occur within ten days following the site visit. For zero of seven individuals (0%) were all of the required assessments available in the O drive as required by policy. It was noted that Facility QA data affirmed the lack of timely assessments. *The QA/QI Council Meeting: Data Analysis Report* for Section F, dated August 18, 2011, indicated there had been significant regression in this area in May, June and July 2011. Internal	Noncompliance

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		monitoring indicated compliance levels of 54.5%, 33.3%, and 36.4% for the three months respectively. PST members did not always take personal responsibility for ensuring they were aware of information needed to complete an accurate and thorough assessment. This was true across a number of disciplines. Examples included: • In the area of behavioral health, Individual #119 was admitted about one year ago for problems of severe emotional dysregulation with mood lability, anger, irritability, impulsivity, agitation, anxiety, depression oppositional/antisocial, poor frustration tolerance, and lack of coping skills. The Individual's presentation was complex and required careful differential diagnosis and data-based interdisciplinary discussions. However, although psychiatric symptoms of impulsivity, aggression, mood lability, and suicide gestures were identified in psychiatric clinic notes, no psychiatric symptoms were tracked until July 2011, making an otherwise excellent functional assessment done by psychology that month much less helpful. The process of evaluation and treatment was unacceptably slow, and the integration of planning of the PSP suffered as a consequence. • In the area of Physical and Nutritional Management, a lack of critical thinking in identifying risk as well as lack of discussion surrounding aspiration events was alarming due to the high rate of aspirations occurring at DSSLC. Per review of the Pneumonia list provided by DSSLC, 78 episodes of pneumonia occurred during the last quarter accounting for approximately 15% of the population at DSSLC. Based on a sample of twelve individuals (Sample #1 in Section O) 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: o Individual #117 had a choking event on 8-15-11. On 8-16-11, the OT conducted an observation but there was no evidence of a tableside swallowing assessment. Additionally, the OT stated that findings and recommendations would follow but there was no evidence that this occurred. o Individual #519 was diagnosed with aspiration pneumonia on 4/11/11 but there was no evidence of comprehensive reassessment upon return from the hospital. There was evidence of the PST meeting to discuss the event but the discussion was limited to the need to defer programming and did not focus on potential indicators or triggers that led to the aspiration event. o Individual #211 was diagnosed with aspiration pneumonia on 6/6/11 but there was no evidence of comprehensive reassessment upon return from the hospital. The PST met on 6/11/11 and decided to defer programming until	

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		return from hospital. The team also stated that they would meet upon return from the hospital but there was no evidence that this occurred. There was some evidence of the PST meeting to discuss the event but the discussion was limited to the need to defer programming and did not focus on potential indicators or triggers that led to the aspiration event. It was also noted that the Facility's monitoring processes revealed that assessments did not consistently identify individuals' strengths, preferences and needs. For example: • The Section F Monitoring Tool for Individual #312, completed on 8/19/11 for a PSP developed on 5/26/11, indicated preferences were identified in the PFA and the Life Skills Annual Report, while strengths and needs were identified in the Functional Skills Assessments and Life Skills Annual Report. The other assessments were found not to have addressed strengths, preferences and needs. • The Section F Monitoring Tool for Individual #512, completed on 6/16/11 for a PSP developed on 2/23/11, found the assessments did focus on strengths and needs of the individual, but not as much on preferences. It also revealed there was no PFA in the record. • For Individual #656, there was no PALs or Functional Skills assessments completed, so the PSP had little to no basis for the identification of strengths or needs.	
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.	This component was found to be not in compliance. Current assessment practices at DSSLC, in terms of timeliness, accuracy and thoroughness, did not provide assessment results that could adequately be used to develop, implement, and revise as necessary, a PSP that outlines the protections, services, and supports to be provided to the individual. As described in F1c, assessments required to develop an appropriate PSP meeting were frequently not done in time for PST members to review each other's assessments prior to the PSP meeting, nor are assessments completed with sufficient thoroughness. Even when the results of this flawed assessment process were used in the development of the PSP, the PSTs did not consistently use the available results appropriately to develop, implement, and revise the PSP as necessary. While the *QA/QI Council Meeting: Data Analysis Report* for Section F indicated the Facility had made significant progress in this area, their own data reflected continued poor outcomes in May (25%), June (62.5%) and July (50%). Examples encountered by the Monitoring Team included: • Individual #779's PSP included a 2001 Speech assessment; however a more recent speech assessment conducted in 2010 was not referenced and integrated into the PSP. • The PSP did not always reflect an up to date understanding of behavioral issues.	Noncompliance

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		Examples included: o Individual #197 was diagnosed several years ago with a thyroid disorder, and mood problems were understood to be associated with this condition. The Individual was provided with medication treatments for the thyroid condition and for mood. The thyroid problem was corrected and the individual's antidepressant was gradually tapered and now discontinued. These issues were not reflected in the PSP. It is possible that had the fuller information on behavioral healthcare been provided, action plans #2 (creative leisure) and #3 (community outings) would have been written with more ambitious goals. o Individual #114 has been diagnosed with Intermittent Explosive Disorder (IED) for the past 15 years, to reflect difficulties with physical aggression, property destruction, and unauthorized departures. He was started on medications around the same time. Over the past two years, his two psychiatric medications were withdrawn; however after several months, difficulties reemerged. In May of 2011 his diagnosis was reevaluated, and he was diagnosed with dysthymia due to chronic and recurrent patterns of withdrawal from social, recreational and training activities, refusal for self- care and healthcare needs, irritability, and appearing sad. The behavioral health care modified his treatment and added information, for example that the rates of target behaviors usually increase when he is ill or when he experiences an exacerbation of mood symptoms. The PSP was written in July 2011, and did not reflect the current overall understanding of the individual's behavioral healthcare needs and supports. • In the area of positive behavior support: o For individual #163, information was included in the summary of the functional assessment that indicated "[The Individual] is highly verbal and often seeks interaction from her peers and caregivers. She is quite capable of telling you that she doesn't want to do something and asking for things that she wants or needs. It is only when her verbal behavior is no longer effective at meeting her needs that she will begin to display maladaptive behavior." Nevertheless, the identified replacement behavior was, "Appropriate Task Refusal: When [the Individual] is presented with a task that she does not want to do, she will state 'I do not want to do that.'" As the person was acknowledged to possess this skill and to use it on a regular basis, it was doubtful that efforts to strengthen this behavior would be necessary or produce meaningful changes in the individual's undesired behavior.	

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F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	This provision was found to be not in compliance. 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 PST as a whole and the members individual serve as the state's qualified professionals for this purpose. It was noted that team members at DSSLC had recently been provided clarification and training as to their individual responsibilities to make a recommendation about the most integrated setting. The Monitoring Team attended three PSPs and one PFI and also reviewed seven 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. Findings included some signs of progress as well as a number of continuing concerns. On a positive note, it was observed during the three PSPs meetings during the site visit (100%) that each staff person was asked by the facilitator to provide a verbal assessment of the individuals' most integrated setting. This was a positive step, but was not yet reflected in the PSP assessment documents. A review of the assessments for Individuals #46, #334, #546, and #566 for recently completed PSPs found that there were no (0%) professional recommendations regarding the most integrated setting. It was also noted that professional staff may not always have fully comprehended the Olmstead decision or their roles in relationship to its requirements. For example, for Individual #80, one staff gave a verbal assessment that the individual continue to reside at the Facility based solely on the potential cost of dental services in the community. This indicated a lack of understanding as to the role of the professional to provide an assessment of the potential for the most integrated setting, including recommendations for the supports, services and protections needed and that setting. It was not clear that all of the trained facilitators were competent in the facilitation of this discussion of most integrated setting at the PSP meeting. For example, during the PSP for Individual #61, the facilitator did initiate a discussion of community living options by asking the individual's cousin, who represented the family, if she would like to become more educated on these options. The cousin responded by saying she was not necessarily opposed to that, she just wanted someone to explain to her why that would be the goal for the individual. The facilitator did not use this opportunity to discuss either the philosophical basis for the concept of most integrated setting, nor of potential benefits for the individual. Instead, the facilitator stated it wasn't necessarily the goal, and that it wasn't necessary to plan for a move to the community, but that it was necessary to develop a related Action Plan as a part of the PSP. This led to a further	Noncompliance

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		discussion of whether the cousin might become the individual's LAR, to which the facilitator suggested obtaining guardianship could be the Action Plan. It was not clear this would be undertaken for the purpose of facilitating a move to the most integrated setting, even though the PST members has all indicated the community would be that setting for the individual. PST members, including facilitators, continued to need additional training in how to facilitate an appropriate discussion of the most integrated setting with family members and LARs. It is recommended the Workgroup for Sections F, T and U develop strategies in this area.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:	This provision was found to be not in compliance, based on the noncompliant sub-provisions as detailed below.	
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	This provision was found to be not in compliance. Facility QA data affirmed this finding. *The QA/QI Council Meeting: Data Analysis Report* for Section F, dated August 18, 2011, indicated there had been significant improvement in this area in May, June and July 2011, but, despite this improvement, the Facility's performance remained well below a standard of compliance. Internal monitoring indicated compliance levels of 35%, 35% and 52.6% for the three months respectively. The PSPs at the Facility did not consistently build the PSP on individual's preference and strengths. For example, for Individual #269, the PST determined that it was important for the individual to have regular visits with a cousin, and that family contact was "vital" to the individual's ability to live a meaningful life at DSSLC or in the community. Although there was narrative in the PSP regarding strategies to support this need, the PST did not develop any Action Plan, nor did any visits occur over the course of a year. The PSPs at the Facility did not consistently address identified barriers nor provide an explanation for any need or barrier that was not addressed. For example: • For Individual #508, the PSP from 9/10 indicated the individual's mother stated	Noncompliance

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		she wanted the individual to live closer to home. The mother stated she wanted to visit community living options with the individual to help reduce the anxiety of new situations related to the individual's anxiety disorder. No visits were implemented. • For Individual #627, the PST identified family reluctance as a barrier to the individual's ability to move to the most integrated setting, but developed no Action Plan to address this barrier. PSPs did not consistently reflect encouragement of community participation in any meaningful or purposeful manner. For example, for Individual #80, who enjoyed community activities, the PST stated it would be "unrealistic" to develop an Action Plan for the individual to participate in community activities at least once per week. Action Plans related to community integration activities that were developed tended to be general statements without any clear purpose toward promoting community integration. Examples included: • For Individual #334, an Action Plan had a desired outcome for the individual to participate in leisure and work-related activities to promote successful future transition to the community. The objective was that "Residential Services will coordinate and schedule opportunities" for the individual to participate in campus and community-based activities and events. The PST did not provide specific guidance or details as to the supports needed or the specific purpose for the activities that would support future transition, • For Individual #566, the desired outcome was to increase the individual's community awareness. A service objective stated the individual would be "provided with opportunities to attend preferred community outings." No specific details or purpose related to community awareness was provided. The Active Treatment Department had begun to attempt to create meaning and purpose for community integration activities by correlating community outings with other objectives for specific individuals, and providing varying level of instructions for staff as to training to be implemented during the activities. This was a new endeavor, which was to be commended for its intent, but will require significantly more organization if it is to be successful. The Monitoring Team also recommends that the PSTs should take the primary responsibility for specifying the purposes for community activities, including, for example, how these activities support preferences and personal goals, training needs for functional skills, and increasing community awareness. The PSTs should develop an integrated approach, including not only purpose, but types of activities and minimum frequencies, to facilitate this learning.	
	2. Specifies individualized,	This provision was found to be not in compliance. Facility QA data affirmed the lack of	Noncompliance

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	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;	timely assessments. *The QA/QI Council Meeting: Data Analysis Report* for Section F, dated August 18, 2011, indicated there had been significant regression in this area in May, June and July 2011. Internal monitoring indicated compliance levels of 56.5%, 37.5% and 43.8% for the three months respectively. The PSP did not consistently specify individualized, observable and/or measurable goals/objectives to attain identified outcomes related to each preference and meet needs. For example, the following specific areas of concern were noted during the review of skill acquisition programs: • Behavioral objectives and definitions. It is essential that efforts to strengthen skills include specific behaviors or skills to be increased, the level of success that the individual is expected to achieve, and the time within which that success would be achieved. In many cases, the goal for a training program consisted of only a general statement that did not clearly indicate what specific skill or behavior was to be increased. As a result, it was not evident how the objective related to the specific needs of the individual or contributed to enhancing the individual's abilities. For example, a Training Objective for Individual #337 stated only that the individual would identify community roles and services. • Description of teaching conditions: In order for teaching programs to be implemented as intended, the staff implementing those programs must be given explicit instructions including what materials to use, how those materials are to be presented, where training should be conducted and how the environment should be controlled. Without such instructions, training procedures often drift or change across staff and location. As a result, training is ineffective and can strengthen the wrong behavior. The training programs reviewed at DSSLC during the current site visit often lacked details and failed to ensure that training would be implemented consistently. For example, for Individual #778, the teaching methodology indicated that staff were to take the individual to the store to buy a magazine, show her the magazine rack, and prompt her to choose one. These instructions did not provide staff with sufficient information about how training was to be implemented. • Sufficient trials: It has been repeatedly demonstrated in research regarding learning that the development of skills requires repetition. In the majority of cases, while the skill is initially being learned, high rates of repetition are required so that the individual is provided multiple opportunities of reinforcement. Often, the lower the frequency of reinforcement opportunities, the slower the rate of learning. If the rate for reinforcement opportunities falls too low in relation to a specific behavior, that specific reinforcement may not effectively and efficiently compete with other reinforcement in the environment. In the majority of skill acquisition programs reviewed at DSSLC, the teaching	

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		trials were provided at a rate of one per day or less. • Consequences for incorrect responses: The majority of training programs at DSSLC included the provision of potential reinforcement following a successful display of the target behavior. In order for training to be most effective, however, in many cases there must also be a consequence for an incorrect response that reduces the probability of future incorrect responses. For example, if attention is reinforcing for an individual and is used to reinforce successful displays of the target behavior, the consequence for an incorrect response might involve withholding attention for a few seconds. This serves to weaken undesired responses and strengthens the power of the reinforcement used for correct responses. None of the training programs reviewed at DSSLC included consequences for incorrect responses. In many instances, the PSP did not specify individualized, observable and/or measurable goals and/or objectives, or the treatments or strategies to be employed to overcome identified barriers to living in the most integrated setting appropriate to his/her needs. Please refer to Provision T1b1 for examples.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	This provision was found to be not in compliance. 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 Provision F1c, assessments required for the PSP meeting were frequently not completed in time for PST members to 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. The Monitoring Team did find some progress in this area. There were some examples of improved integration observed in planning meetings and record reviews, including the following: • For Individual #80, the PST developed a recycling work program around the individual's affinity for soda cans, his desire to have money, and his apparent lack of interest in his current work program. The PST integrated preferences with functional work and money management, and proceeded to brainstorm many ways the team could support the individual in this new venture. • For a number of individuals, the behavioral healthcare was integrated, and the joint behavioral formulation was presented well in the PSP. This contributed to more meaningful and integrated overall support plan. Examples included: o Individual # 551 was recently admitted to the Facility after transfer from another facility. The diagnosis was reviewed, updated, and appropriate symptoms were identified for behavioral tracking.	Noncompliance

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		Following appropriate consultation between psychiatric and psychological staff, and with the involvement of the broader PST, a decision was made to reduce the individual's medication, with careful tracking in place to monitor for reemergence of identified target symptoms. To date, the medication reductions were proceeding as planned and the individual was doing well and the progress was reflected in the PSP. o Individual #307 had been diagnosed in the past with obsessive compulsive disorder. Following review, the diagnosis was changed to generalized anxiety disorder and psychiatric treatment was modified accordingly. The PBSP and the PSP contain good descriptions of the individual's behavioral symptoms, and the manner in which medication and environmental interventions serve to reduce his symptoms and challenging behaviors. Sometimes, however, behavioral healthcare needed better coordination. For example, Individual #119 was admitted about one year ago for problems of severe emotional dysregulation with mood lability, anger, irritability, impulsivity, agitation, anxiety, depression oppositional/antisocial behavior, poor frustration tolerance, and lack of coping skills. The Individual's presentation was complex and required careful differential diagnosis and data-based interdisciplinary discussions. However, although psychiatric symptoms of impulsivity, aggression, mood lability and suicide gestures were identified in psychiatric clinic notes, no psychiatric symptoms were tracked until July 2011, making an otherwise excellent functional assessment done by psychology that month much less helpful. The process of evaluation and treatment was unacceptably slow, and the PSP suffered as a consequence. In the area of communication, the Monitoring Team found that zero of the 12 records sample reviewed (0%) had a clear rationale and description of communication interventions integrated into the PSP. Examples of PSPs in which communication was not adequately integrated included: • Individual #707's PSP just mentioned that facial expressions were used to communicate. • Individual #702 PSP simply stated that no speech treatment was needed. • PSPs at times 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. • There was no evidence of detailed strategies or translation of nonverbal skills (i.e., communication dictionary) integrated into the PSP to assist staff with	

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		methods to increase communication. • Zero of the 12 records (sample #8) reviewed (0%) clearly identified how the individual communicates with others and interacts with his surroundings. Examples were provided in Provision R.3. • Zero of the 12 records (sample #8) (0%) reviewed had communication interventions and methods to improve communication integrated into the daily schedule	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	This provision was found to be not in compliance. Specific methods for implementation, time frames for completion, and the staff responsible were not consistently identified. In order to assess an individual's progress toward developing skills and behaviors, it is essential to have valid and reliable data. This in turn requires that personnel who are tasked with collecting data are provided specific and detailed instructions. In many cases, the skill acquisition programs at DSSLC did not provide adequate instructions for data collection. For example, for Individual #337, a skill acquisition program involved completing a task with one verbal prompt. The methodology of the program allowed for up to three verbal prompts. The data collection instructions did not include the procedure for recording multiple prompts. Under most circumstances, once an individual has demonstrated mastery of a task over several sessions, efforts can begin to fade the training and reinforcement procedures. Continuing training beyond mastery in many situations has little benefit for the individual and may create a situation in which participating in training is punishing. In all of the skill acquisition programs reviewed at DSSLC, participation in a skill acquisition program was required for excessive durations beyond mastery before the program could be considered completed. Examples included: • For Individual #54, a skill acquisition program written in April 2010 had continued unrevised for 17 months. A review of the data reflected mastery of the skill occurred several months prior to the site visit. There was no indication the program was being considered as having met completion. • For Individual #334, a program required that the individual demonstrate mastery for three consecutive months before the program would be considered to be completed. In addition to skill acquisition programs, other descriptions of supports did not always identify methods for implementation. For example, as described in Provision M.3, HMPs did not contained adequate instructions to specify to the nursing staff the frequency interventions/actions were to be carried out, by whom, where, and when to document interventions/actions that were taken.	Noncompliance

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	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	This provision was found to be not in compliance. Proposed interventions, strategies, and supports were not always effectively designed to address the individual's needs for services and supports in a manner that was practical and functional. For example: • For Individual #80, the PST developed a recycling work program and a related money management program for an individual who the team indicated needed routine related to his autism diagnosis. The team then recommended that the money management portion of the strategy be implemented once per month. This frequency of training would not have been practical for the individual nor effectively result in any real learning. • For Individual #648, the PST developed a training program related to dental desensitization that required him to listen, upon request, to a lecture regarding the dentist 85% of the data trials for 3 consecutive months by 5/05/11. The training was to take place each Friday morning and had no methodology that otherwise related it to dental care in any way, nor any expected outcome other than to comply with the instruction to sit and listen to the lecture. In addition, interventions, strategies, and supports were not always consistently implemented to result in functional learning. For example, staff did not consistently implement interventions and recommendations outlined in the PNMP and/or Dining Plan. Other examples of failure to effectively and consistently implement the interventions, strategies, and supports are described in Provision F2c. Services and supports were not consistently developed that were practical and functional in community settings, as further described in Provision F2a1. There was some progress noted, such as a substantial increase in the number of community outings that occurred in the second quarter of 2011. Although the number of outings reversed slightly with the onset of Summer, the number of monthly community outings remained substantially greater than earlier in the year. Some progress was also demonstrated in community employment for individuals living at DSSLC. During the previous site visit, six individuals were employed in the community. During the current site visit, it was noted that there were now 11 individuals with community jobs.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the	This provision was found to be not in compliance. PSPs at DSSLC did not consistently or adequately identify 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. Examples included: • For Individual #168, the treatment expectation was that the rate of appropriate refusal would be 80% of trials or greater for 8 consecutive months by 8/10/2012. This required the individual to successfully learn the behavior and	Noncompliance

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	individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	continue participation in the program for eight months, even if the target decreased shortly after program implementation. • For Individual #526, treatment expectations were that, "Episodes of SIB will be reduced to 40 or fewer episodes per month for 6 consecutive months by 06/02/2012." According to these guidelines, there were no specific stipulations to provide guidance to the PST that the PBSP should be reviewed for efficacy prior to 6/2/2012 and consideration given to need for revision if, for example, the rate of SIB increased substantially. • For individual #590, the treatment expectations for 250mg of Seroquel per day were indicated to be, "Ongoing treatment for maintenance." This expectation provided no guidance for what would be considered as a need to revise pharmacotherapy. • For Individual #334, an SPO provided the following instructions for data collection: When to collect data (Day(s) and Time): Tuesday I Friday 7:00-9:00 pm How to collect data (Using codes below): If successful, Place a "+" in box If unsuccessful, Place a "-"in the box These instructions did not instruct the staff for which specific behaviors to record success or failure. For Individual #334, the same SPO provided the following instructions for data recording: With a single gestural prompt, [The Individual] will sort his clothes in dark and light piles. If [the Individual] places a piece of clothing in the correct pile, give him verbal praise and encourage him to continue. If [the Individual] does not place clothing in the correct or does not select clothing, with a single gestural prompt (pointing) encourage [the Individual] to select a specific piece of clothing and place it on the correct pile. If [the Individual] places the clothing on the correct pile, encourage him to continue. If [the Individual] does not select the correct clothing or place it on wrong pile, begin again with the demonstration. Attempt the training at least 5 times. If [the Individual] sorts his all his soiled clothing by color, place a"+" in the box. If [the Individual], does not sort all of his soiled his clothing by color, place a"-" in the box. It was not clear from the instructions exactly how many trials were to be conducted. In addition, the instructions did not make clear whether a "+" should be marked regardless of the number of prompts required or only if the individual placed clothing in correct piles with just a demonstration. Finally, a more sensitive measure of progress would be the percent of trials placed correctly in the pile with only a gestural prompt.	

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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.	This provision was found to be not in compliance. There was a lack of coordination observed in the coordination of goals, objectives, anticipated outcomes, services, supports, and treatments in the PSP. Examples included: • For Individual #384, the Speech-Language Pathologist had recently been evaluating the individual for use of an augmentative communication device. Neither the Speech-Language Pathologist nor any other member of the PST was aware the individual had a PSP Action Plan to receive training on using certain hand signals to indicate yes or no. The QDDP was not aware this was included in the current plan and it was not being implemented. • For Individual #61, much of the PSP meeting centered on the ability of the individual to communicate when in pain as a means of reducing aggressive behavior towards others. The PST did not develop a coordinated strategy among psychology, speech-language therapy, medical/nursing and other disciplines to address these needs.	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.	This provision was found to be not in compliance. When interviewed by the Monitoring Team, five of five direct care professionals (100%) 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. DCPs at 507A were easily able to find the PNMP and PSP for an individual in the Individual Notebook. On the other hand, as described in Section V, not all needed information was always accessible. For example, the PNMP was located in the individual notebook that followed the person; however individuals not residing on Houston Park or Cedar Falls did not have their books follow them and therefore the PNMPs were not readily available to staff. At no time during any of the observations was staff observed referring to the PNMPs, and no evidence was observed that the PNMP was found in any other book at the sites where these individuals received services. In other instances, the PSP could not be said to be fully accessible to staff responsible for implementation as certain Action Plans were not implemented as prescribed. For example, as described in Provision F2b, the QDDP had not provided staff with an individual's communication program as required in the PSP. • Observations and review of program data indicated PSPs were also not consistenty written so as to be comprehensible tostaff responsible for program implementation. Examples found throughout Section F of deficiencies that negatively impacted comprehensibility included:As described in Provision F2a1, the Monitorng Team found examples of Action Plans and programs that did not provide adequate direction to staff as to the specific activities to be undertaken to support community integration and awareness for Individuals #334 and #566.	Noncompliance

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		• As described in Provision F2a4, the Monitoring Team found, in many cases, the skill acquisition programs at DSSLC did not provide adequate instructions for data collection. For example, for Individual #337, a skill acquisition program involved completing a task with one verbal prompt. The methodology of the program allowed for up to three verbal prompts. The data collection instructions did not include the procedure for recording multiple prompts. • As described in Provision F2a4, Provision M.3 documented that HMPs did not contain adequate instructions to specify to the nursing staff the frequency interventions/actions were to be carried out, by whom, where, and when to document interventions/actions that were taken. Another outcome measure as to staff comprehension of their responsibilities for implementation is whether the PSP is actually implemented correctly. The Monitoring Team found numerous examples, of staff failing to implement the PSPas written, , including: • Mealtime observations demonstrated that staff failed to implement 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: o In only two of 11 (18%) observations, were staff following mealtime plans. o In only six of 11 (54%) observations were staff following positioning instructions. • In 512C, staff appeared unfamiliar with the modes of communication used by the individuals living there. Despite the apparent confusion, staff made no attempt to use communication devices that were available.	
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	This provision was found to be not in compliance. The responsible interdisciplinary team member(s) for each program or support included in the PSP did not consistently assess the progress and efficacy of the related interventions or take action as needed if there was a lack of expected progress. For example: • For Individual #61, it was identified in last year's PSP that the team would provide supports for the individual to visit an elderly mother and niece at least once per month. No visits were made during the entire year, nor was any documentation made as to this support. At the new PSP meeting held during this site visit, the niece again identified this as a support that continued to be needed, and the team concurred. No rationale was offered as to why the visits had not been arranged.	Noncompliance

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	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.	• For Individual #61, there was an Action Plan to participate in a community tour by 10/31/11, but this was not implemented nor any rationale offered. • For Individual #384, there was a training objective to learn to indicate yes or no by raising a left or right arm respectively. The QDDP was unaware this training objective was in place. • For Individual #445, the PBSP was in excess of one year old. Behavior data did not reflect benefit from the intervention, yet the PBSP was extended for an addition six months on 7/20/2011. These examples were consistent with the Facility's own data that indicated compliance with this requirement standing at just 38% for the quarter ending July 2011. Section F monitoring tools provided examples of the failure to adequately monitor progress and revise the PSP as needed: • For Individual #205, the monitoring tool stated the PSP was not revised when there was no progress on objectives although the QDDP indicated she would make revisions but did not follow through. • For Individual #541, the monitoring tool noted a training objective or money management had shown no progress for three months and the QDDP replied the objective had lapsed. However, the TDR was still being used for data collection and no revised money management program had been implemented.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the	This component was found to be not in compliance. The facility must 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	Noncompliance

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	implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	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. It was encouraging that DSSLC had initiated enhanced training and mentoring of staff in relation to the development and implementation of skill acquisition training programs. However, based upon the observations and document reviews completed as part of the current site visit, it was evident that DSSLC still needed to make significant improvements in preparing staff to provide meaningful and functional supports and to implement active treatment effectively.	
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.	This provision was found to be not in compliance. The Facility reported one admission (#119) during the past six months. The PSP meeting was held within the required thirty days of admission, but certain deficiencies remained in the process, including assessments that were not completed within 30 days and training objectives that were not implemented in a timely manner. For example, the implementation date for six TDRs was stated to be 05-16-2011, but none were implemented before 6/14/2011. Two were not implemented until 7/17/2011. The Facility should track the timeliness of requirements related to new admissions in a manner that allows time for remedial action to be taken within the 30-day window. The Facility reported it no longer was tracking dates when the annual PSP is filed in the records, so did not have data to provide the Monitoring Team for review. Neither the Facility nor the Monitoring Team had the information needed to ensure PSPs were revised annually, nor to ensure PSPs were revised more often than needed.	Noncompliance

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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.	This provision was found to be not in compliance. The Facility had implemented a quality assurance process that was intended to identify a level of compliance with the requirements of Provision F. The Facility used a monitoring tool that cross-referenced the Settlement Agreement requirements with ICF-MR standards. The Monitoring Team requested and reviewed all of the monitoring tools completed for this provision over the period of 6/1/11-8/31/11. Of the 12 completed tools, all but one were for PSPs completed prior to the last six months, and some as long ago as July 2010; therefore, these did not provide sufficiently timely information that might enable the Facility to remediate issues related to the content and substance of the PSP. The Facility should consider how to select a sample that would provide timely information that could support remedial action. Even for those items related to plan implementation, such as an assessment of ongoing plan revisions, there was no documentation of follow-up remedial action made available to review. The Facility should clearly identify and state its expectations and requirements regarding how, when and by whom remedial action will be taken when specific deficiencies are identified and how completion of these actions is ensured. The Facility also continued to use the Q Audit and PSP Meeting Monitoring Checklist processes. The Workgroup for Sections F, T and U should evaluate how these processes, and the data they produce, can be fully integrated into a more comprehensive QA process.	Noncompliance

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

1. The Facility should devote immediate and sustained attention to remediate the failure of PSTs and individual team members to conduct comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs. (Provisions F1c, and F1d)
2. The Workgroup for Sections F, T and U should develop strategies in the area of additional training for PST members, including facilitators, in how to facilitate an appropriate discussion of the most integrated setting with family members and LARs. . (Provision F1e)
3. The PSTs should take the primary responsibility for specifying the purposes for community activities, including, for example, how these activities support preferences and personal goals, training needs for functional skills, and increasing community awareness. The PSTs should develop an integrated approach, including not only purpose, but types of activities and minimum frequencies, to facilitate this learning. (Provision F2a1)
4. The Facility should resume tracking of PSP dates for timeliness of annual reviews in order to ensure and demonstrate compliance with this requirement. (Provision F2f)
5. DSSLC should provide much more detailed information and specification in policy or other protocol as to how training associated with PSP implementation for specific individual PSPs is expected to occur. (Provision F2e)
6. The Facility should track the timeliness of requirements related to new admissions in a manner that allows time for remedial action to be taken within the 30-day window. (Provision F2f)
7. The Facility should consider how to select a sample for QA monitoring to provide timely information that could support remedial action. (Provision F2g)
8. The Facility should clearly identify and state its expectations and requirements regarding how, when and by whom remedial action will be taken

when specific deficiencies are identified in the QA process and how completion of these actions is ensured. (Provision F2g)

9. The Workgroup for Sections F, T and U should evaluate how the several QA processes, and the data they produce, can be fully integrated into a comprehensive QA process. (Provision F2g)

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Plan of Improvement (POI), dated 9/7/2011 2. DSSLC Presentation Book for Sections G, H, and 3. DADS Draft Policy Minimum and Integrated Clinical Services 1/12/10 4. Active Records for Individuals #205, #469, and #551 5. Individual Notebook for Individual #119 6. PSPs, CLDPs, and other documents reviewed by the Monitoring Team 7. 7. Consultation reports for Individuals #19, #59, #102, #270, #277, #279, #291, #332, #336, #413, #438, #441, #467, #478, #496, #580, #627, #657, #697, and #787 **People Interviewed:** 1. Group interview with Dr. Stephen Kubala, Director of Medical Services, Randy Spence, Director of Behavioral Services, and Donna Groves, Director of Habilitation **Meeting Attended/Observations:** 1. PSP Annual Planning Meeting for Individual #373 2. At Risk Team Meetings for Individuals #102 and #306
	Facility Self-Assessment: The Facility reported that it did not yet comply with either provision of this Section. The Monitoring Team concurs. The Facility reported that inservice training had been provided to ensure review of recommendations from non-Facility clinicians but did not provide indication of evaluation to determine whether this had any effect. The Facility also reported beginning a new process for notification of the PST when a meeting is needed upon significant change in health status; this was a recent change, and the samples drawn by the Monitoring Team did not yet reflect this action. The current POI simply reported on actions taken, rather than evaluating whether the actions taken are producing the desired outcomes, and why or why not. The POI did not provide many details as to the Facility's self-assessment processes, but rather listed actions the Facility had taken since the last visit and, in some cases, provided a list of Action Steps and completion status. The Facility should consider how it may more fully use its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes. For example, the Facility could gather data on whether Facility clinicians review recommendations from non-Facility clinicians and document adoption or review by the PST, perhaps through the records audit process or QDDP review; this would provide data that could be used to assess status, rather than simply reporting that inservice training was completed.
	Summary of Monitor's Assessment:

	The Monitoring Team concurred that neither provision was yet in compliance. Nevertheless, the Monitoring Team did find continuing progress toward compliance. The Facility involved more disciplines in systemic reviews, such as infirmary rounds, morning medical meetings, and committees such as the pneumonia workgroup. PSP attendance by clinicians had improved, but there was still need for additional participation. The PBSP was in process of revision to document more clearly the integrated case formulation and involvement of psychiatry and behavioral services. Facility clinicians documented review of most, but not all, consultations by non-Facility clinicians. Nearly all recommendations were accepted.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The Facility has taken steps toward providing clinical services in an integrated manner. The basis for integration is the PSP process; clinicians have attended the Supporting Visions PSP training. By interview and observation, the Monitoring Team determined that participation of clinician in the PSP process has improved somewhat, although there remains room for improvement. As reported in Provision F1b, attendance at PSP meetings in August 2011 was routine for nursing, whereas psychologists participated in fewer PSP meetings. SLP attendance had increased since the last compliance visit. Psychiatrists participated in the PSP meetings held during this visit. The Director of Medical Services reported that physicians continued to participate in PSP meetings, and this was observed during the visit. The Facility reported that additional steps had been taken to increase integration of planning and services. • The morning medical report meeting participation was expanded. At least weekly, the pharmacy, psychiatrist, and CNE attend to review information. A representative of Behavioral Services was reported to attend morning report daily to address behavioral issues. Per report of the Medical Director, the hospital nurse liaison participated daily to provide information on individuals in the hospital and to do joint planning for individuals who would be returning. The Director of Habilitation Services reported that a representative of the Physical and Nutritional Management Team (PNMT) participated daily in infirmary rounds, and that the RN Case Management Supervisor participated to identify changes in risk levels. • A core group met monthly to work on issues relating to reducing incidence of pneumonia. This group included the Director of Medical Services and the Director of Habilitation Services. In addition, the Facility reported that, with the	Noncompliance

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		participation of the Infection Control Nurse, data on pneumonias were shared at IMRT weekly. • Speech and Language Pathologists (SLPs) have provided input into the development of Positive Behavior Support Plans, according to the Director of Behavioral Services, and a SLP continued to serve on the Positive Behavior Support Committee (PBSC). • Efforts to increase integration of psychiatric services with other clinical services continued. o Staff psychiatrists attended neurology clinics, and a process for review and oversight of medications prescribed by both neurology and psychiatry was in place. o As reported in Provision j.8, psychiatry clinics observed by the Monitoring Team showed excellent interdisciplinary planning, including clinicians, DCPs, the individual, and families in the discussion. The discussions during the clinic were clinically relevant and included meaningful exchanges of information and perspectives by the individuals and PST members. o Psychiatrists were well integrated into the Facility Medical Department and worked side-by-side with somatic care medical providers in many settings, including Facility committees such as Pharmacy and Therapeutics Committee (P&TC) and polypharmacy. While PCPs did not always attend Psychiatric Treatment Reviews, they participated in required treatment steps (see, for example, Provision J.10) by telephonic and individual conversations with the psychiatrists. Nurses were active collaborators and they participated in psychiatry clinics. o As reported in Provision J.2, psychiatrists provided information from behavioral healthcare colleagues (e.g. psychologists), other healthcare colleagues (e.g. medicine, pharmacy, and nursing) and from the broader PST. This information was typically located in the case formulation and treatment sections of the record. There was documented evidence in records of individuals with such conditions that the Wound Care Nurse collaborated with other relevant disciplines to provide integrated care. Participation of other modalities of treatment (such as speech and language) was less evident in PST processes, although many times they are essential parts of an interdisciplinary treatment program. Although nurses were actively involved in the PST process, there were issues in which greater involvement would be important. Systemically, health care plans were not	

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		integrated with other disciplines, with exception of the instructions provided to direct care professionals. On an individual level, nurses could make better use of the PST to improve health care in some cases; for example, the routine refusal of individual #537 to not allow necessary assessment could be detrimental to the early identification and treatment for changes in health status. The RN Case Manager should refer Individual #537's refusal to allow the physical assessment to the PST, particularly the Behavior analyst, to consider remedies to resolve the problem. The working relationships at the Facility between psychology and psychiatry were excellent, there was good expertise in both clinical departments, and psychiatry was a part of the treatment team. Nonetheless the Monitoring Team had identified in previous reports that the efforts of the two clinical departments were insufficiently integrated: Collaborative diagnoses occurred rarely, and there was a poor flow of clinical information/data to the appropriate clinical venues and to key enduring documents that guide treatment. Previous reports of the Monitoring Team have emphasized that although there were many excellent clinicians in the Departments of Psychiatry and Psychology, there were problems in the flow of clinical information, so that the right information was brought together in the right venues and in the appropriate formats, in a manner that facilitated the development of integrated and cohesive behavioral health care programs. During the past six months the Facility made three decisions that address this matter positively: • A decision was made to reformat the PBSP so the key psychiatric information regarding diagnosis and treatment was provided consistently in the PBSP. The new format was implemented starting August 1, 2011. • A decision was made to try to include language that described the combined case formulation for the individual, as part of the PBSP. • Psychiatrists will start to sign the PBSP along with their colleagues from psychology, thus affirming that the PBSP is a shared core document that outlines an integrated behavioral healthcare program. To summarize, Provision G1 is not in compliance, but many steps have been taken toward compliance. To reach compliance with this provision, the Facility will need to demonstrate that the processes implemented to provide information and review cases across disciplines actually result in joint planning and case formulation. A draft DADS statewide policy had also been available for a number of months. 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	

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		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.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The Monitoring Team reviewed 51 consultations provided for 20 individuals to determine whether a Facility clinician reviewed the recommendations and documented adoption or referral to the PST. For 47 consultations (92%), there was documentation of review of the recommendations by a Facility clinician, usually by initial and date; for four of the 51 consultations (8%), there was no evidence found of either review by the Facility clinician or of acceptance, rejection, or referral to the PST. For 46 of the 47 consultations that did document review of the recommendation by a Facility clinician(98%), there was evidence in the record (through IPN notes or physicians orders) of acceptance of the recommendations; for the other consultation, there was no evidence of acceptance, rejection, or referral to the PST. The Facility should implement a process to ensure documentation is made of review, and of acceptance, rejection, and/or referral to the PST. It would be advisable for such a system to provide clear reference to the orders, IPN notes, or PSPAs that result from the review of recommendations so they could easily be tracked by the Facility and by external peer reviewers.	Noncompliance

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

1. Add to the draft DADS policy by 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. (Provision G1)
2. Provide training, review and mentoring, or another process to assist clinicians to develop integrated case formulations and treatment recommendations and to develop documentation that clearly demonstrates this integration in PSPs and the active record. (Provision G1)
3. The Facility should implement a process to ensure documentation is made of review, and of acceptance, rejection, and/or referral to the PST. (Provision G.2)

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Plan of Improvement (POI), dated 9/7/2011 2. DSSLC Presentation Book for Sections G, H, and 3. DADS Draft Policy Minimum and Integrated Clinical Services 1/12/10 4. Active Records for Individuals #205, #469, and #551 5. Individual Notebook for Individual #119 6. PSPs, CLDPs, and other documents reviewed by the Monitoring Team 7. 7. Consultation reports for Individuals #19, #59, #102, #270, #277, #279, #291, #332, #336, #413, #438, #441, #467, #478, #496, #580, #627, #657, #697, and #787 **People Interviewed:** 1. Group interview with Dr. Stephen Kubala, Director of Medical Services, Randy Spence, Director of Behavioral Services, and Donna Groves, Director of Habilitation **Meeting Attended/Observations:** 1. PSP Annual Planning Meeting for Individual #373 2. At Risk Team Meetings for Individuals #102 and #306
	Facility Self-Assessment: The Facility reported that it was in compliance with only Provision H.2. The Monitoring Team concurred, except that it did not find compliance with Provision H.2; although diagnoses were consistent with the ICD or DSM, they did not always provide complete documentation of criteria or diagnostics to be sure the diagnoses clinically fit assessments or evaluations. The Facility reported a number of actions that had been taken. Most actions occurred too recently to have been effective at establishing compliance at this visit. For example, the Facility reported it had developed forms and procedures to track clinical indicators and appointments for chronic care health issues in August and September 2011; the samples selected for reviews throughout this report were unlikely to include much to document that these were implemented. The current POI simply reported on actions taken, rather than evaluating whether the actions taken are producing the desired outcomes, and why or why not. The POI did not provide many details as to the Facility's self-assessment processes, but rather listed actions the Facility had taken since the last visit and, for Provision H.1, provided a list of Action Steps and completion status. Some actions did not appear relevant to the provisions, although they were likely relevant for other provisions or sections of this SA. For example, for Provision H.1, the Facility reported it had developed a doctor to doctor transfer form to communicate with provider when people move to the community to transfer appropriate documents to the accepting physician; although this is a good idea, it does not reference carrying out the assessment required in Section T nor improving the quality of that assessment and how it can be used to identify supports that might be essential for health.

	The Facility should consider how it may more fully use its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes. For example, the Facility had data about timeliness of completing assessments that could have been used for self-assessment but was not included in the POI.
	Summary of Monitor's Assessment: The Monitoring Team found that none of the provisions of this Section were yet in compliance. Adequacy of assessments and evaluations remained problematic at this visit. Throughout this report, there are examples in which assessments were not routinely completed on a timely basis. When assessments were completed, the PSTs did not consistently use the available results appropriately to develop, implement, and revise the PSP as necessary. Diagnoses generally were consistent with the ICD or DSM classifications. However, they did not always fit assessments and evaluations. The Facility had begun to monitor treatment of chronic health conditions. Assessment and treatment of chronic conditions should be more aggressive and comprehensive. There is not routine use of clinical indicators to monitor health status of individuals or in aggregate to demonstrate efficacy of clinical practice at the Facility.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	Adequacy of assessments and evaluations remained problematic at this visit. Throughout this report, there are examples in which assessments were not routinely completed on a timely basis. As reported in Provision F1d, assessment practices at DSSLC, in terms of timeliness, accuracy and thoroughness, did not provide assessment results that could adequately be used to develop, implement, and revise as necessary, a PSP that outlines the protections, services, and supports to be provided to the individual. As described in Provision F1c, assessments required to develop an appropriate PSP meeting were frequently not done in time for PST members to review each other's assessments prior to the PSP meeting, nor are assessments completed with sufficient thoroughness. The Monitoring Team found an overall lack of rigor in the assessment processes at DSSLC. As reported in Provision F.1d, even when assessments were completed, the PSTs did not consistently use the available results appropriately to develop, implement, and revise the	Noncompliance

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		PSP as necessary. Facility QA data affirmed the lack of timely assessments. *The QA/QI Council Meeting: Data Analysis Report* for Section F, dated August 18, 2011, indicated there had been significant regression in this area in May, June and July 2011. Internal monitoring indicated compliance levels of 56.5%, 37.5% and 43.8% for the three months respectively. There had been improvement in initiating assessments within five working days of an individual being identified as at risk. There was documentation that the PST started the assessment process as soon as possible but within five working days of the individual being identified as at risk for 11 (79%) individuals. Nevertheless, there were examples where this was not done. As reported in Provision O.2, based on a review of 12 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. Completion of assessments within 30 days of an admission was inconsistent. Although most assessments were completed, not all were. For example, for the one individual who was admitted since the last compliance visit, the PT/OT evaluation was completed within 30 days but the communication assessment was not. All individuals who required psychiatric evaluations had received them. Psychiatric evaluations were completed in the required format. In many cases the psychiatric formulations and diagnosis provided the PSP with information needed to best support the individual. In some cases this was not done. Functional assessment of behavior had also continued to improve. In many areas, the functional assessments completed by the Facility were approaching the level of substantial compliance. However, little progress was achieved by DSSLC in integrating adaptive and intellectual testing into the psychological assessment process. As reported in Provision M.2, most but not all nursing assessments were completed timely, and not all included all required components. Nineteen of the 28 (67%) Annual and Quarterly Comprehensive Nursing Assessments reviewed were completed according to the individuals' PSP schedule. Although the assessments were not completed on time, they were either found completed after the due date, or were in process. Fewer than half of the Annual/Quarterly Comprehensive Nursing Assessments reviewed were completed according to the requirements. Somewhat over half of the nursing summaries reviewed adequately summarized each nursing problem/diagnosis to indicate individuals' status of progress related to their	

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		specific condition. Training nurses on physical assessment was in process.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	Psychiatric diagnoses were in the DSM IV format, and medical diagnoses were consistent with the current version of ICD. For psychiatric diagnoses, progress had been made in substantiating psychiatric diagnoses in terms of DSM IV or DMID criteria, but, as reported in Provision J.6, there was still a need for improvement. Furthermore, there were occasions where the diagnosis made could be supported, but it did not account for the symptoms that were the focus of the psychiatric treatment. Medical diagnoses generally fit the corresponding assessments and evaluations. However, as reported for some cases in Provision L.1, there were times when additional diagnostics might have provided valuable information but were not ordered.	Noncompliance
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.	The Facility did not have a plan or procedure in place to ensure or monitor that treatments and interventions were implemented timely. The POI reported only that a chronic care quarterly visit and chronic care medical appointment tracking were implemented 9/1/11; presumably, these are intended to address interventions for individuals with chronic health conditions. This provision, though, is not limited to chronic health conditions but instead relates to all clinical services. It is, however, positive that the Facility is addressing chronic health conditions. As reported in Provision L.1, the Facility lacked aggressive and comprehensive management of spasticity, PKU, and diabetes mellitus. The incidence of pneumonia at the Facility indicates the possibility that treatments and interventions to prevent pneumonia were not timely and appropriate. For example, observations of the living area demonstrated serious problems in the area of positioning, especially for individuals who were fed per enteric tubes. This must be addressed by a number of clinical disciplines, including habilitation services, nursing, and medical services. There are additional examples reported in Provision L.1 in which there was inadequate follow up of health conditions and lab results. Provision O.2 provides examples in which an individual's health status changed but no meaningful assessment or change in treatment ensued. As reported in Provision M.3, there had only been a slight improvement in the quality of Health Maintenance Plans (HMPs), which provide plans to address health care needs.	Noncompliance

#	Provision	Assessment of Status	Compliance
		HMPs continued to lack adequate individualization to meet individuals' needs. Goals and objectives established for the HMPs were not consistently clinically appropriate, realistic, and measurable in relation to the identified health problems. The HMPs included interventions/actions to address the immediate problem but rarely contain proactive interventions directed at preventing or minimizing the specific health risks. The HMPs did not contained adequate instructions to specify to the nursing staff the frequency interventions/actions were to be carried out, by whom, where, and when to document interventions/actions that were taken. The Facility should establish a process to assess whether treatments and interventions are timely. The Facility should use the peer review processes that address other Sections of the SA to ensure treatments are clinically appropriate.	
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.	No change had occurred in the way Facility clinicians use clinical indicators for evaluating health status of conditions for individuals. The Facility provided no descriptions of clinical pathways or guidance on specific indicators to guide clinicians and PSTs. The Medical Director reported two changes in processes regarding use of clinical indicators: • Monitoring of clinical care was done through the morning meetings, and monitoring of chronic care had begun. • The Facility had begun to monitor cases from the PNMT through to resolution. As multiple individuals go through this process, the Facility expects to learn what needs to be addressed. The Monitoring Team understands that DADS continues the process of developing clinical indicators of health status and guidelines for care. In July 2011, the Infection Control Preventionist began conducting surveillance of infection control practices system wide and reported significant findings to appropriate committees. Data were not being trended yet, but these data could provide information relevant to clinical indicators of system-wide health care status. While PNMPs were 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). Furthermore, when occupational therapy and physical therapy supports were provided to individuals, there was no assessment as to the effectiveness of the interventions.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The aspiration trigger sheet being developed at the time of the last compliance visit had been implemented. Nevertheless, there was a lack of use of clinical indicators regarding physical and nutritional services. Although aspiration triggers were to be reported, the following issues remained that prevented the information from being useful as clinical indicators of status: • 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. • Lack of consistent and detailed documentation surrounding the occurrence of triggers (e.g., activity in which trigger occurred, positioning of the individual). • Lack of consistent completion by staff (missing data points). • Trigger sheets contain information that was not relevant to the individuals (i.e., an individual who eats by mouth had a trigger that states to watch for formula in the mouth) As reported in Sections J and K, the psychology and behavioral services departments had been working together to identify symptoms and behaviors to track in order to assess effectiveness of mental health treatment. That process was ongoing at the time of the visit.	
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.	One approach used by the Facility to monitor the health status of individuals was the risk assessment process implemented in January 2011. Although this process holds promise for monitoring and addressing health status in an integrated manner, the PSTs were still learning how to address risks accurately and effectively. In several sections of this report, there are examples in which risk was not re-evaluated following risk incidents (for example, on return from hospital) or where risk levels were not assigned accurately. A second means for monitoring health status is the monitoring of implementation of treatments and interventions. 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

#	Provision	Assessment of Status	Compliance
		clinician. As reported in Provision M.3, HMPs continued to lack adequate individualization to meet individuals' needs. Goals and objectives established for the HMPs were not consistently clinically appropriate, realistic, and measurable in relation to the identified health problems. Therefore, they currently were not as valuable as they should be for monitoring and reporting health status of individuals. Although there had not been systemic development of clinical indicators, the QA/QI Council followed key indicators for health care including data on aspiration pneumonia and falls. The Facility is in process of deciding how to break down and focus the data. 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.	
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.	The Facility did not have clear guidance on the use of clinical indicators or on when treatments and interventions should be modified. In the medical arena, DADS is working on selecting or developing clinical pathways, which should include such guidance. There were instances in which clinical indicators that signaled a need for reassessment and possible modification of interventions did not lead to those actions. For example: • For Individual #445, the PBSP was in excess of one year old. Behavior data did not reflect benefit from the intervention, yet the PBSP was extended for an addition six months on 7/20/2011. • For Individual #214 (reported in Provision L.1), a person diagnosed with quadriplegia and other orthopedic conditions, the OT/PT assessment dated 2011 provided appropriate assessment of arm and leg movements, and they recommended a program to help maintain functional range of motion. There were no data, however, used to determine if the individual's condition was worsening, improving or unchanged. The PSP did address the PT/OT assessment.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and	A draft DADS state policy addressed provisions G and H together. The policy was not yet 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	guidelines to implement the provisions of Section H.	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).	

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

1. The Facility should establish a process to assess and track whether treatments and interventions are timely. (Provision H.3)
2. 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. (Provision H.5)

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 9/7/11 2. DSSLC Policy CMGMT -14 At Risk Individuals 1/1/11 3. List of Health Risk Ratings for each risk factor/individual 8/24/11. 4. Records reviews for Individuals #19, #117, #118, #211, #279, #291, #306, #386, #401, #438, #466, #519, #557, #576, #580, #697, and #757 5. Integrated risk reviews for Individuals #19, #117, #118, #211, #279, #291, #306, #386, #401, #438, #466, #519, #557, #576, #580, #697, and #757 6. Risk Action Plan for Individuals #3, #19, #117, #118, #211, #279, #291, #306, #386, #401, #438, #466, #519, #557, #576, #580, #697, and #757 7. List of Top 10 aggressive individuals causing injury to peers 8. List of Top 10 injured individuals. 9. List of individuals supported with bedrails 10. List of individuals injured from bedrails **People Interviewed:** 11. Donna Groves, OTR, Director of Habilitation Services 12. Joy Sibley SLP, Director of Communication Therapy 13. Lori Powell, Director of Quality Assurance 14. Randy Spence, M.S., Director of Behavioral Services **Meetings Attended/Observations:** 15. Incident Management Team (IMRT) 9/19/11 16. Restraint Reduction Committee 9/22/11 17. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 9/20/11 18. At Risk Team Meetings for Individuals #102 and #306
	Facility Self-Assessment: The Facility's self-assessment reported the DSSLC was not in substantial compliance with any provision or component of this section of the Settlement Agreement (SA). The Facility reported it had initiated and provided training on the revised risk assessment procedure and that procedures were in place to follow the revised State policy. The Facility also reported in its POI that it had developed a process to ensure the PST meets after hospitalizations or other significant events to review risk ratings and revise ratings and action plans as needed. This was accomplished by the RN Case Manager in each living area doing a morning report on health status changes and providing notification to the PST. The Monitoring Team's review substantiated this self-assessment.
	Summary of Monitor's Assessment: The DSSLC processes to demonstrate compliance with this section of the SA were insufficiently organized to achieve the desired results. The statewide risk assessment procedure, with improved guidelines for rating risk, had been initiated. However, in 21% of records sampled, risk assessments were not conducted

	within five working days of risk identification or a change in circumstances. Additionally, professional staff implementation of the Risk Assessment policy was inconsistent indicating a need for additional training and professional oversight. Interdisciplinary discussion required to properly assess risk and develop risk mitigation strategies was not always apparent to the Monitoring Team. For example, in many records sampled, the Monitoring Team determined that assessments were not sufficiently comprehensive to enable interdisciplinary discussion. The lack of work flow organization, and professional oversight of the risk assessment process, prevents the DSSLC from identifying risk timely and appropriately, which in turn prevents the development of timely and appropriate risk mitigation plans. 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. In one risk meeting conducted for the Monitoring Team as a learning experience, significant interdisciplinary discussion was observed. Much of this discussion, however, relied on anecdotal data and impressions offered by various PST members rather that objective data relevant to specific risk assessments.

#	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.	The DSSLC reported in its POI it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. The statewide risk assessment procedure, with improved guidelines for rating risk, had been initiated. The Monitoring Team observed two PSP meetings held during the week of the review. Staff present at the PSPs was the actual staff who worked with the individual. The individual was present at both meetings. The PST used the Risk Level Guidelines established as part of the new state procedure for assessing and managing risk when determining risk levels. The PSP meetings observed by the Monitoring Team included a full and open discussion among PST members although discussion of risk assessment was not based on clinical data. For example, during the PSP meeting for Individual #373 some limited clinical data was presented but discussion and decisions consisted largely of "clinical judgment" which was not necessarily directly related to data. During the PSP meeting for Individual #102 the PST relied almost exclusively on clinical data offered by the RN Case Manager and had almost no discipline related data to contribute to the discussion. Additionally, this meeting ended before risk level assignments could be determined by the team.	Noncompliance

#	Provision	Assessment of Status	Compliance
		On a positive note the PSP meeting for Individual #373 demonstrated interdisciplinary discussion, back and forth, until risk ratings were agreed upon by the PST. This PST was also able to take several risk areas that were inter-related and develop one action plan to address the risk. Neither PST engaged in substantive discussion on how risk impacted potential alternative placement. In one meeting (Individual #102) the PSP facilitator kept the team discussion focused. The other meeting (Individual #306) was less organized and, in fact, ran out of time before risk ratings could be developed and agreed upon. The Monitoring Team requested that two PSTs participate in special meetings to go through their reviews of risk for an individual. In one risk meeting significant interdisciplinary discussion was observed. Much of this discussion, however, relied on anecdotal data and impressions offered by various PST members rather that objective data relevant to specific risk assessments.	
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.	The DSSLC reported in its POI it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. Review of 14 records for individuals initially determined by the PST to be at risk (Individuals #19, #118, #279, #291, #306, #386, #401, #438, #466, #557, #576, #580, #697, and #757) showed there was documentation that the PST started the assessment process as soon as possible but within five working days of the individual being identified as at risk for 11 (79%) individuals. Records that did not contain documentation of this requirement included: Individuals #386, #576, and #757. The records of these 14 individuals were reviewed to determine if changes in circumstance should have resulted in changes to an at-risk assessment, rating, and plan. There were examples of risk events or changes in status. When anything about an individual's life changes in a manner that would likely effect risk status the PST must start an assessment process as soon as possible but within five working days of the individual changes. In the Monitoring Team's sample, an at-risk condition for 11 (79%) individuals had changed. Three records did not contain documentation of this requirement: Individuals #306, #386, and #757. Based on a review of records of a sample of six individuals (Individuals #19, #291, #438, #279, #580, and #697) for whom assessments had been completed to address the individuals' at risk conditions, two (33%) included an adequate nursing assessment to assist the team in developing an appropriate plan. The records that did not contain	Noncompliance

#	Provision	Assessment of Status	Compliance
		documentation of this requirement were for Individuals #19, #291, #279 and #580. The following provides an example of an assessment that was not comprehensive: the assessment for Individual #291 did not contain adequate rationale in all risk categories from various disciplines to provide adequate information from which an accurate assessment of risk could be logically determined. Based on a review of records of a sample of five individuals (Individuals #118, #401, #466, #279, and #557) for whom assessments had been completed to address the individuals' at risk conditions, none (0%) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in developing an appropriate plan. The following provides an example of an assessment that was not comprehensive: Individual #466 was recommended to have the head of the bed elevated. The assessment did not contain information as to why the recommended degree of elevation was appropriate or that it was individualized to the Individual. Based on a review of records of four individuals (Individuals #19, #306, #386, and #757) with challenging behavior risk ratings, for whom assessments had been completed to address the individuals' at risk conditions, none (0%) included a psychiatric assessment to assist the team in developing an appropriate plan. Separate from the records reviewed for data tabulation the Monitoring Team identified other issues. For example, only one of 12 (8%) individuals who were diagnosed and/or hospitalized with a PNM issue was assessed by the PNMT or PST. • Individual #117 had a choking event on 8-15-11. On 8-16-11, the OT conducted an observation but there was no evidence of a tableside swallowing assessment. Additionally, the OT stated that findings and recommendations would follow but there was no evidence that this occurred. • Individual #519 was diagnosed with aspiration pneumonia on 4/11/11 but there was no evidence of comprehensive reassessment upon return from the hospital. There was evidence of the PST meeting to discuss the event but the discussion was limited to the need to defer programming and did not focus on potential indicators or triggers that led to the aspiration event. • Individual #211 was diagnosed with aspiration pneumonia on 6/6/11 but there was no evidence of comprehensive reassessment upon return from the hospital. The PST met on 6/11/11 and decided to defer programming until return from hospital. The team also stated that they would meet upon return from the hospital but there was no evidence that this occurred.	
I3	Commencing within six months of the Effective Date hereof and with	The DSSLC reported in its POI it was not yet in compliance with this provision of the SA. The Monitoring Team concurs.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Based on a review of 14 records for individuals determined to be at risk there was documentation that the Facility: • Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate in eight (57%)) cases. Records that did not contain documentation of this included Individuals #19, #291, #306, #386, #576, and #757. • Implemented a plan that met the needs identified by the PST assessment in seven (50%) cases. Records that did not contain documentation of this included Individuals #19, #306, #386, 438, #576, #580, and #757. • Included preventative interventions in the plan to minimize the condition of risk in eight (57%) cases. Records that did not contain documentation of this included Individuals #19, #306, #386, 438, #576, and #757. When the risk to the individual warranted (eight cases), the Facility took immediate action in six (75%) cases. • Integrated the plans into the PSPs in eight (57%) cases. Records that did not contain documentation of this included Individuals #306, #386, #438, #576, #697, and #757. • In nine (64%), the risk plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. Records that did not contain documentation of this included Individuals #19, #279, #386, #438, and #757. • In two (14%), appropriate functional and measurable objectives were incorporated into the PSP to allow the team to measure the efficacy of the plan. These were for Individuals #580 and #697. • Included the clinical indicators to be monitored and the frequency of monitoring in three (21%) cases. These were for Individuals #438, #580, and #757. The Monitoring Team was unable to identify risk management/mitigation plans that were comprehensive and individualized to the extent that if followed risk would be effectively managed or mitigated. An example of a plan that was inadequate to adequately address risk factors was Individual #3 who had a recent aspiration event (8/3/11). The risk plan for this Individual was not updated resulting in no action being taken to comprehensively address the change in status. Other examples include Individuals #19 and #438 whose action plans were extremely generic, lacked measurable objectives, and were deficient in providing the level of specificity that would guide staff in risk mitigation activities.	

#	Provision	Assessment of Status	Compliance

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

1. The Facility should assure all PSTs are provided with training and ongoing technical assistance on implementation of the At Risk policy and its incorporation into the PSP process. (Provisions I.2 and I.3)
2. QMRPs/Team leaders should be provided with competency based training and job coaching on implementation of the At Risk policy and its incorporation into the PSP process. (Provisions I.2 and I.3)
3. Ensure that appropriate and timely 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. (Provision I.3)

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken To Assure Compliance:** **Documents Reviewed:** 1. DSSLC Plan of Improvement (POI) 9/7/11 2. Presentation Book for Section J, including all information on actions taken to reach compliance, forms and procedures for monitoring status of the Facility relevant to this section, and other information to document compliance or progress 3. DADS Policy and procedure 001: Use of Restraints (08/15/09) 4. DADS Policy and Procedures 007.2 Psychiatry Services (08/30/11) 5. DSSLC Policy and Procedure CMGMT-21: Dental/Medical Sedation and Restraint (11/05/09) 6. Sample #1: (Individuals #19, #50, #60, #90, #114, #119, #171, #197, #240, #307, #371, #386, #402, #417, #530, #551, #587, #606, #624, #637): a. Social History b. Most recent Personal Support Plan (PSP) c. Most recent Health Risk Assessment Rating – tool and team meeting sheet d. If the individual is assessed at high risk on the basis of polypharmacy or challenging behaviors – copies provided of the plan to reduce risk e. Medical and/or Dental Plans to increases cooperation/participation (hygiene, desensitization, etc) f. Most recent Positive Behavior Support Plan (PBSP) g. Most recent Safety Plan h. Most recent Functional Behavior Assessment i. Most recent Annual Medical Summary j. Most recent Annual Nursing Summary k. Most recent Annual Pharmacy Summary l. Most recent Annual Psychiatric Review/Psychotropic Medication Review m. Most recent Active Problem List n. Most recent Psychiatric Evaluation (unless already provided under item # 3 above) o. All Psychiatric Medication Reviews for the past six months p. Most recent MOSES/DISCUS Side Effects Screenings q. Most recent Quarterly Drug Regimen Review (QDRR) r. Reiss Screen s. Most recent Neurology Consultation; t. For any new psychotropic medications prescribed during the past six months and for annual renewals of psychotropic medications that have been in place, materials provided in response to request: i. Any information from the clinical record (e.g., progress notes, psychiatric treatment reviews) that will help the Monitoring Team understand the reasons/clinical rationales for choice of the medication ii. Medication Plans (MP) for the new psychotropic medications

	iii. Informed Consent (IC) for use of the psychotropic medications iv. Review of the psychotropic medication by the BSRC and Human Rights Committee (HRC) 7. Sample #2 (Individuals #255, #306, #372, #451, #743): Clinical materials reviewed included Medication Plans (MPs) and Informed Consent (IC) forms for the named medication, most recent Psychiatric Evaluation, PBSP, Psychiatric Medication Review (PMR) 8. Sample #3 (Medical Restraint) Individuals #21 (6/22/11), #35 (04/20/11), #170 (07/12/11), #425 (04/13/11, #493 (05/11/11), #537 (04/06/11), #554 (06/07/11), #639 (05/18/11), #656 (06/16/11), # 435 (03/25/11): 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, and other documentation associated with the restraint use 9. Sample #4 (Reiss Screens): Individuals #2, #45, #75, #83, #97, #121, #126, #136, #144, #169 #170 #190, #196, #208, #237, #252, #270, #304, , #320, #323, #329, #332, #367, #376, #394, #409, #416, #435, #437, #474, #499, #508, #519, #532, #534, #560, #566, #570, #581, #595, #608, #656, #657, #665, #670, #699, #701, #710, #727, #733, and #769. Materials reviewed included Reiss Screen data sheets and Reiss Screen scoring sheets (two raters) 10. Sample #5 (Neurology Clinic) Individuals #64, #285, #289, #313, #321, #353, #370, #382, #449, #489, #530, #533, #539, #557, #616, #690, and #766: Materials reviewed included neurology clinic notes, labs, and minutes from the clinic for each individual 11. Changes or updates in policies, procedures, and/or other documents that relate to the work of psychiatrists 12. A list of all individuals who receive psychiatric care, the current psychiatric diagnosis for each individual, and the name of the psychiatrist to whom each individual is assigned for care 13. All Appendix B psychiatric evaluations completed since the last compliance on-site review 14. Since the last compliance review, a list of any individuals for whom the psychiatric diagnosis has been revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s) 15. For the last six months, a list of all psychotropic medications newly approved for prescribing to an individual by PBRC and HRC, including the medication that was approved, the name of the psychiatrist assigned to the individual, and the date(s) of approval 16. A spreadsheet of individuals prescribed psychotropic/psychiatric medications including the name of individual, residence/home, diagnoses; and medication regimen 17. Lists of individuals for whom each of the following was prescribed: Anti-epileptic medications used as a psychotropic medications, lithium, tricyclic antidepressants, Trazodone, beta blockers being used as a psychotropic medication, Clozaril/clozapine, Mellaril, Reglan, anticholinergic medications, and benzodiazepines. 18. A list of individuals prescribed intra-class polypharmacy, including the names of medications prescribed and each medication's start date 19. Minutes of the Polypharmacy Committee and minutes of the Pharmacy and Therapeutics Committee (P&TC). 20. Summary of Dental /Medical Desensitization Psychological Assistant Job Responsibilities

	21. Psychiatry department spreadsheet that contained information on all individuals supported by psychiatrists, their diagnoses, and psychotropic medications. **People Interviewed:** 1. Sibylle Graviett, RN, RN Case Manager Supervisor 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. Delia Schilder, RN, CDDN, CNE 6. Randi Spence, MA Director of Psychology 7. Terese Thomas, Dental/Medical Desensitization Psychological Assistant 8. Jill Wooten, BCBA, Positive Behavior Support Committee (PBSC) Chair **Meetings Attended/Observations:** 1. Psychiatric medication reviews (PMRs) and quarterly psychiatric reviews (QPRs) for Drs. Salam and Satpathy (Individual #216 and Individual #488) 2. PSP meetings (Individual #61 and Individual #80) 3. Polypharmacy Review Committee (PRC) meeting (09/20/11)) 4. QA/QI meeting (09/20/11) 5. P&TC meeting (09/21/11)
	Facility Self-Assessment: The Facility self rated for substantial compliance on eight provisions. These were provisions J1, J2, J5, J7, J10, J11, J12, and J15. In all cases, these ratings corresponded to the findings of the Monitoring Team that are contained in this report. The Facility self-rated as not in substantial compliance on seven provisions. These were provisions J3, J4, J6, J8, J9, J13 and J14. For five of these provisions, however, the Facility listed steps taken in response to suggestions made by the Monitoring Team. In all these areas, the Monitoring Team agreed that the steps taken to improve procedures and formats were positive steps. These included: • The Psychiatry Department improved documentation of rationales for the use of psychotropic medications in the treatment plan and communicated to Facility providers to ensure that Active Problem Lists included correct psychiatric diagnoses (Provision J.3). • The Director of RN Case Managers developed guidelines for nursing responsibilities during medical restraint on the Outpatient Medical Consultation/Procedure form and trained nurses in the use of the form (Provision J.4). • The Facility Lead for section C updated the medical/dental restraint policy and procedure, specifically those sections related to medical restraint. The contract psychiatrist monitored records (Provisions J.6, J.8). • There was a new format for the PBSP (Provision J.8). The self-assessment did not report on available data about decreases in the rates of polypharmacy. These were important data about Facility progress and they should have been included.

	The Facility's action plan for psychiatry focused on efforts to determine treatment efficacy through psychiatry and psychology collaboration, and review of data in the psychiatric clinics. The Monitoring Team agreed that this is the correct focus; the recommendations for section J in this report are largely in these areas.
	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. MPs outlined why each medication was used, but there needed to be further progress in the areas of linking medication treatment plans to symptoms or behavioral characteristics of identified psychiatric disorders, and the tracking of data that will help determine whether the medication is effective. **For provision J4:** The provision was determined to be not in compliance. The Facility had added staff to assist the process for the development of desensitization plans for identified individuals, but that process remains at a very early stage. Procedures for monitoring during medical restraints had improved. **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 used Appendix B evaluations for new admissions, annual reviews, and consultations. However, additional focus was needed to assure that documentation was adequate to fully substantiate psychiatric diagnoses in terms of all the symptoms required to fulfill DSM IV or DMID diagnostic criteria. **For provision J7:** The provision was determined to be in substantial compliance. Reiss screens were administered to all individuals who required them. **For provision J8:** The provision was determined to be not in compliance. A recent revision of the PBSP and work processes around that document has helped provide more integration between the behavioral healthcare disciplines, but the new format had just been implemented. There have also been improvements in the PSP, but in several cases the Monitoring Team found that relevant behavioral information had not been included in the PSP.

	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 had improved, but the required elements of the provision were not always documented. **For provision J10:** The provision was determined to be in substantial compliance. Participation of the PCP in risk/risk assessments can now be verified. A substantially compliant process is in place but, as noted in the previous report, the Facility should continue to improve its process by providing clarification/assurances about the way in which reasonable alternatives to treatment were considered. **For provision J11:** The provision was determined to be in substantial compliance. The Psychoactive Medication Oversight Committee was providing effective clinical oversight in the area of polypharmacy, and data for the past two years continued to show a gradual and sustained decrease in the amount of interclass and intraclass polypharmacy. **For provision J12:** The provision was determined to be not in compliance. Facility wide monitoring of side effects was in place, and the nursing staff provided training in the administration of MOSES forms for documentation of overall side effects and DISCUS screens for tardive dyskinesia. However, several screenings did not have documentation to substantiate review by psychiatrists. **For provision J13:** The provision was determined to be not in compliance. Medication Treatment Plans had improved and now included clear rationales for the proposed treatments. The system to monitor 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.	There were no changes in staffing at the Facility since the last visit. DSLLC continued to employ three full time staff psychiatrists: Drs. Lin, Satpathy and Salam. The fourth psychiatrist, Dr. Harden, was employed as a contractor for eight hours per week. Drs. Harden, Salam and Satpathy were board certified by the American Board of Psychiatry and Neurology, and Dr. Lin was board eligible. There were no significant changes in their curriculum vitae, medical licenses, and specialty board certificates.	Substantial Compliance

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		During the tour the Monitoring Team observed the work of the psychiatrists during PMRs and QTRs, during two annual PSP meetings and during meetings of the PRC and P&TC. The Monitoring Team again found that the psychiatric staff at DSSLC consisted of qualified professionals, who participated meaningfully in the DSSLC interdisciplinary process.	
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 Facility reported that 259 individuals received ongoing psychiatric care; 253 of these individuals (97%) received psychiatric medications. The Facility reported that all individuals supported by psychiatry received annual psychiatric evaluations. The evaluations were in the SA Appendix B format. Each evaluation was accompanied by MPs for each of the psychotropic medications the individual received (see Provision J.13). The psychiatry department maintained a spreadsheet that listed all individuals who received psychiatric support, their DSM IV diagnosis/diagnoses, and any psychotropic medications they received as part of their ongoing medication regimen. The spreadsheet was updated on an ongoing basis. The Monitoring Team examined the records from Samples #1 and #2. All records contained a psychiatric evaluation. With one exception, the most recent evaluation had been done during the twelve months that preceded the visit. The exception was Individual #60, whose psychiatric evaluation was dated 04/09/2010. In each case, the psychiatrist who completed the most recent evaluation was the psychiatrist who provided the ongoing care for the individual ("attending psychiatrist"). Accordingly, all evaluations were done by board certified or board eligible psychiatrists. The Monitoring Team examined the information contained in the evaluations, and asked the following questions: 1. <u>Did the evaluation include information from PST functions?</u> For individuals who lived at the Facility for the year preceding the evaluation, the psychiatrists typically included information gathered as part of their ongoing care of the individual in the psychiatric clinics (during PMRs and QPRs). Such information was listed in the history of present illness section of the assessment. Twenty four of the individuals reviewed had lived at the Facility throughout the previous year. Individual #551 had been admitted to the Facility during the year. For that Individual, the history of present illness section included information from PST functions that took place since admission to the Facility, as well as information from providers who supported the individual prior to admission. To further understand psychiatric information gathered during PST functions, the	Substantial Compliance

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		Monitoring Team attended two psychiatric clinics (PTRs/PQRs) that took place during the visit, and reviewed in detail the materials reviewed and the notes written during clinic visits for Individuals #488 and #216. Each clinic appointment was scheduled for 45 minutes. Clinic appointments were attended by the individual being reviewed, by the psychiatrist and psychiatry assistant, the individual's nurse case manager, psychologist, qualified development disability professional (QDDP), DCPs, other Facility staff as appropriate, and sometimes the Guardian/LAR (in person or by telephone). Overall attendance for each review was 8-10 individuals. The psychiatrist and the QDDP led the meetings, and the psychiatrist interviewed or observed the individual. The psychiatrist then obtained updates about the individual's progress since the previous review. Depending on the acuity of the individual's situation this could have been quite recent or as much as three months (which was the maximum interval between psychiatric visits for individuals who took medication). During the meetings there was discussion between the various participants and the individual, and treatment goals and progress were reviewed. Treatment recommendations/decisions were then made, guided by the elements of the individual's PBSP that were listed in the materials prepared by the psychologist for the clinic visit (such as psychiatric and behavioral data graphs). The psychiatrist recorded these deliberations, discussions, and decisions in a handwritten note, which was later filed in the individual's record. Although the individuals reviewed during the clinic visit did not include individuals in Samples #1 and #2, the kind of review and discussion that was observed corresponded to descriptions of the PST process that were recorded in the psychiatric evaluations. That process was substantive and clinically solid. Overall, psychiatrists demonstrated considerable knowledge about the individual and his/her history and clinical circumstances. There was active collaboration between the psychiatrists and other professionals. 2. <u>Did the psychiatrist include information from colleagues?</u> Psychiatrists provided information from behavioral healthcare colleagues (e.g. psychologists), other healthcare colleagues (e.g. medicine, pharmacy, and nursing) and from the broader PST. This information was typically located in the case formulation and treatment sections of the record. Relevant materials were located in 23 of 25 (92%) of the evaluations. The exceptions were Individual #551 (newly admitted) and Individual #60 (evaluation in an older format that did not include the information). The Monitoring Team witnessed the quality of the work of contributing colleagues from nursing, psychology and others during the PMR/QPRs, described above. 3. <u>Was there information that reflected or contributed to annual PSP meetings?</u> Annual psychiatric evaluations were scheduled prior to the individual's annual PSP	

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		meeting. This gave psychiatrists an opportunity to reflect on plans made during the prior PSP, and to make contributions to the new PSP through their recommendations. These contributions included suggestions about community placement preparedness. For example, for Individual #19 the psychiatrist documented in the psychiatric evaluation that the Individual could benefit from living at a group home in the community, that the less restrictive option has been discussed with the guardian, and the plan going forward would be to pursue group home visits. During the visit the Monitoring Team also attended two PSP meetings (for Individual # 61 and Individual #80). In each case the psychiatrist attended the PSP. The psychiatrists contributed to the overall discussion with comments that reflected good knowledge of the individual. 4. Was appropriate historical information cited in the evaluation? Psychiatrists included historical information about individuals, such as past psychiatric history, family history, developmental history and social history. Inclusion of those materials indicated that the psychiatrist was familiar with documents about long term and historical information that had been obtained by the Facility from family members and prior providers. All 25 records reviewed contained such materials. To more broadly explore diagnostic and therapeutic practices that were reflected in the psychiatric evaluations, the Monitoring Team conducted additional analyses, which were: 1. A comparison of psychiatric targets and behavioral treatment targets: The Monitoring Team investigated whether Facility professionals had determined which behavioral symptom/targets were addressed by behavioral treatments, which were addressed by psychiatric interventions, and why. Under provision J.13 of this report, the Monitoring Team compared the behaviors that were described as targets of psychotropic medication (per the psychiatric evaluation MPs) and the target behaviors described in the Functional Analysis (FA) and Positive Behavioral Support Plans (PBSP). Many of the MPs contained targets that were also listed by the psychologist in the FA and PBSP. However, 92% of the 50 medication plans also contained at least one target that was a core DSM symptom of the psychiatric diagnosis that the psychiatrist had associated with the medication. This supported a conclusion that in the records examined, medications appeared to be used to treat psychiatric disorders, and were not used merely for behavior control. 2. Accuracy with which Diagnoses were tracked by the Facility: Active Problem Lists (APLs) were located for each of the 20 individuals for Sample #1, and psychiatric diagnoses were recorded in individuals' records in the APLs, alongside all other medical diagnoses. The psychiatric diagnoses were in the DSM IV format. The Monitoring requested and received a list of diagnoses that were changed/updated during the six months prior to the tour. Facility practice was for the psychiatrist to update the APL in the record when this was done, and APLs reflected the	

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		changes. In one case (Individual #551) the diagnosis was changed after admission and was not updated in the APL. In another (Individual #60) the APL did not list the diagnosis that was in the psychiatric evaluation. In addition to APLs, the Department of Psychiatry maintained a spreadsheet that listed all individuals who received psychiatric support , their diagnoses and their medications. The spreadsheet reflected the changes made during diagnostic evaluations and also changes made during the course of the year. Two additional analyses that related to psychiatric evaluations are reported under provision J6. These are: • An assessment of whether the cited psychiatric symptoms for individuals were sufficient to fulfill the complete diagnostic criteria set forth in the *DSM-IV-TR* or the *Diagnostic Manual of Intellectual Disability (DM-ID*) • An assessment regarding Facility "NOS" and "rule out" diagnoses, based on the guidance provided in the SA. Accordingly, these analyses were included in the discussion for provision J6.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	Materials reviewed for this provision were the records of the 25 individuals in Samples #1 and #2. The Monitoring Team examined individuals' PBSPs, psychiatric evaluations, MPs, ICs PMRs, QPRs and PSPs. The Monitoring Team also considered observations made during visits to PMRs, QPRs, and PSPs, and at meetings of P&TC and the PRC. Minutes of P&TC and the Polypharmacy Review Committee (PRC) for the past six months were reviewed, as were records of chemical restraint episodes for Individual #306 (05/09/11) and Individual #624 (07/05/11). The Monitoring Team examined requirements of the provision, as follows: <u>Psychotropic Medications shall not be in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis or specific behavioral pharmacological hypothesis:</u> Twenty three of the individuals reviewed took psychiatric medications for behavioral indications and all had psychiatric diagnoses. Psychiatric diagnoses were reviewed annually (see J2), but circumstances could occur that required updates in the diagnosis (see J6). The up-to –date diagnosis was listed in the psychiatry spreadsheet that was maintained by the department of psychiatry, and the up-to-date diagnoses were also included in the individual's record, as part of the Active Problem Lists (APLs) that were maintained by PCPs. The Monitoring Team sought to understand the role of psychotropic medications in the individual's overall behavioral healthcare program. To do so PBSPs, MPs and ICs were	Noncompliance

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		reviewed. The Monitoring Team examined records, to determine whether the psychiatric targets and symptoms that were listed in MPs were appropriate for the diagnosis listed on the MP and elsewhere. Fifty medications were investigated, and the detailed analyses are described under provision J13. The results showed that the MPs all contained information on psychiatric diagnosis. In most cases (92%) MPs contained appropriate psychiatric targets that were related to a psychiatric diagnosis of record, and the targets were differentiated from targets of behavioral interventions. <u>Psychotropic medications not provided as a substitute for a treatment program:</u> The Monitoring Team examined the PBSP for evidence of a treatment program. Twenty-four of the 25 individuals (96%) had PBSPs and they provided evidence of an active behavioral treatment program. In all cases the PBSPs acknowledged that individuals received psychotropic medication, and in all cases there were MPs that described the details of the medication treatment. The way in which medication treatment plan information was included in BPSPs at the Facility was in transition, as the formats for both MPs and BPSPs was recently revised (for MPs, effective 07/01/11, and for PBSPs, effective 08/01/11). As reviewed under provisions J8 and J13, many PBSPs did not contain details about the psychiatric treatments that were provided. Consequently, the Monitoring Team could not assess meaningfully whether psychotropic medications were used as a substitute for a treatment program. During the visit, the new format for the PBSP was reviewed with the Lead Psychiatrist and Chief Psychologist. The format appears to include the psychiatric elements that were missing. The format should introduce a degree of transparency and clarity that will help the process of integration of behavioral healthcare programs at the Facility and provide the needed assurance that medications are not used improperly. <u>Psychotropic medications not used for staff convenience or as punishment.</u> To determine whether psychotropic medications were used for staff convenience or for punishment, the Monitoring Team examined clinical records and considered observations made during psychiatric clinics and committee meetings as described under provision J2. There was no evidence that medications were used for punishment or for staff convenience. The Monitoring Team also examined the use of chemical restraints, for Individual #306 (05/09/11) and for Individual #624 (07/05/11). In neither episode of chemical restraint was there any evidence that medications were used for staff convenience or for punishment. The Monitoring Team also explored the broader pattern of medication use at the Facility.	

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		The detailed information is provided under provision J.11, the provision on Facility- wide monitoring of psychopharmacology. Overall, the Monitoring Team found that over the past 2 years there had been a gradual and sustained decline in the number of individuals medicated, and the number who received polypharmacy. Records of the P&TC and PRC suggested that medication reduction plans were focused on individuals whose individual health circumstances support such actions.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	Materials reviewed for the provision were for the ten individuals in Sample #3. The individuals selected were the first five individuals on lists of medical sedation (oral and iv) that were identified in SA Section C. Materials reviewed included restraint checklists, face-to-face assessment & debriefing documents, medical orders, physician specified monitoring schedules, documentation of review activity, and integrated progress notes related to the restraint use. The Monitoring Team met with Sibylle Graviett RN, Case Manager Supervisor, and with Delia Schilder RN, CDDN, CNE, to review how safety monitoring was provided when oral pre-treatment sedation and IV sedation were used for medical and dental procedures. Ms. Schilder and Ms. Graviett informed the Monitoring 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 checklists. Vital signs were obtained per guidelines of the medical restraint guidelines, and monitoring continued in the infirmary until scores of 8 or higher on the REACT measures for level of sedation were obtained and recorded. The Monitoring Team reviewed medical monitoring of medical restraint (pre-treatment sedation) for the ten individuals in Sample #3 C. There were five cases of IV sedation for dental procedures. These were Individuals #21 (06/22/11), #35 (04/20/11), #493 (05/11/11), #537 (04/06/11), and #639 (05/18/11). In each case the Pre-Post-Sedation checklist was used, although for Individual #537 the second page of the checklist that contained vital signs measurements was not received. In all five cases, the Monitoring Team found documentation of a single REACT score of 8 or higher, although the protocol called for two. Vital signs were obtained prior to the procedure except for one individual who declined. In each of the five cases there was follow-up from a nurse on the home unit documenting adequate recovery at home. Five cases of oral sedation for medical procedures were reviewed. These were for Individuals #170 (for a dental procedure on 07/12/11), #425 (for a mammogram on 04/13/11), #554 (for a dental procedure on 06/07/11), #656 (for a mammogram on 06/16/11), and #435 (for a dexa scan and mammogram on 04/07/11). Pre-Post-	Noncompliance

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		Sedation checklists were used in all cases. The required two REACT scores of 8 or higher (or baseline) were not located for any of the individuals. 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). The Monitoring Team determined that only one of the ten individuals who were selected by the Monitoring Team for review of desensitization procedure had a desensitization plan. That was Individual #178, who had a desensitization plan that was cited in the PSP, and there were data collections sheets for the plan that showed that the training had taken place. The Monitoring Team confirmed with Jill Wooten, BCBA, that there are plans to expand the program to provide desensitization plans for all individuals who needed them. Ms. Wooten confirmed that the Facility had hired a psychological assistant to provide medical/dental desensitization, and the Monitoring Team met with the newly hired assistant, Ms. Terese Thomas. In the meeting, the Monitoring Team reviewed the responsibilities for the new hire. These were outlined in the *Summary of Dental /Medical Desensitization Psychological Assistant Job Responsibilities* that was provided to the Monitoring Team by Ms. Wooten. Among other things, the assistant will have the responsibility to write plans using behavioral theories and methodologies, to develop referral forms to be used by PSTs, to refer individuals for desensitization, to review a previous list of individuals with desensitization needs (about 40 individuals), to write formal plans based on Functional Assessments, to review a dental database developed at another SSLC, to do observations in the dental clinic several days per week, to be there every Friday when the dental clinic works with individuals who need formal desensitization, and to suggest environmental changes to the dental clinic. The Monitoring Team would expect that this position would help in development of plans to minimize the need for pre-treatment sedation; the Facility should assess its status in part by reviewing data to see whether this actually occurs.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	At the time of the visit, there were 259 individuals who lived at the Facility and who received psychiatric support. The Facility continued to employ three full time staff psychiatrists and one part-time contract psychiatrist for a total of 3.2 full time equivalent positions. Dr. Salam was the Lead Psychiatrist. In this role she was responsible for many facility-wide activities, which included management of Facility- level reviews such as polypharmacy and management of the Facility- level reviews of individuals known to have tardive dyskinesia.	Substantial Compliance

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		Dr. Harden was a contract psychiatrist who has worked at the Facility for many years, and who continued his activities in the area of quality assurance for psychiatry. Dr. Harden was also a member of the BSRC. The overall clinical caseload for the three full time psychiatrists remained at about 85 individuals per psychiatrist. Drs. Linn, Salam, and Satpathy were the full time psychiatrists who provided direct care to individuals. Psychiatrists participated in routine clinical activities, which included PMRs, QPRs, PSPs and neurology clinics. Psychiatrists also attended medical staff meetings, and participated in committees such as P&T and Polypharmacy. 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. Psychiatric assistants also participated in neurology/psychiatry conferences, tracked the information reviewed, and brought that information to the relevant PMR meetings. The assistants helped the psychiatrists via tracking of labs and other clinical materials. The Monitoring Team asked the Facility to provide a self-assessment regarding how many psychiatry FTEs were needed, based on the number of individuals currently treated in the psychiatry clinic. The Facility was asked to do so on the basis of the number of hours needed to conduct psychiatry clinics, to complete quarterly and annual evaluations, to provide the hours needed for clinical-administrative issues, and to attend meetings where the psychiatrist's attendance is required (e.g. polypharmacy committee, behavior therapy committee, physician's meetings, behavior support planning, PSPs, PSPA). The Facility will provide that self- assessment at the next visit.	
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.	Per the POI, all individuals supported by psychiatry had annual psychiatric evaluations. These were typically done in advance of the individual's PSP. In September 2010 the Facility started to use the Appendix B format for the annual evaluations, and at the time of the visit of the Monitoring Team, the first annual cycle had been completed. The Monitoring Team reviewed the psychiatric evaluations of each of the 20 individuals who comprised sample #1. With one exception, all individuals had an Appendix B evaluation in place that had been done within the past twelve months. The exception was Individual #60 whose most recent psychiatric evaluation was done in April 2010. That evaluation was done prior to the implementation of the Appendix B format and it did not follow that format.	Noncompliance

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		Psychiatric evaluations varied in length from 4 to 12 double spaced pages, and with the exception of individual #60, all contained each of the required sections of the Appendix B format. The assessments were all done by board certified psychiatrists, and all provided DSM IV diagnoses and case formulations. As detailed in the Facility's POI, the Facility had planned for the psychiatric evaluation to be the place where the combined case formulation that was required by provision J8 would be placed. Accordingly, many evaluations concluded with combined formulations and treatment plans for the various behavioral health disciplines. During the visit, the Monitoring Team was informed that the Facility had decided that in the future such formulations will be placed in the PBSP, which will be signed by both psychiatry and psychology. The 20 evaluations included in Sample #1 were reviewed, and the Monitoring Team explored several questions, which were: <u>Were symptoms provided that were consistent with the diagnosis offered by the psychiatrist and adequate to serve as behavioral targets for medications plans?</u> In previous visits the Monitoring Team had encouraged Facility psychiatrists to provide descriptions of symptoms/behavioral characteristics of diagnosed disorders. This was done since the actual symptoms individuals showed could be the basis of diagnoses made, and could be the potential targets for medication treatments. There appeared to be considerable progress in this area. <u>Was documentation adequate to fully substantiate the psychiatric diagnosis in terms of all the symptoms that would be required to fulfill the complete diagnostic criteria set forth in the DSM IV or the DMID?</u> Progress has been made, but additional focus is needed. For example, there were two individuals in the sample (Individual #90 and Individual #119) who were diagnosed with schizoaffective disorder. One of the requirements for that diagnosis is that during the period of the illness, there were delusions or hallucinations or at least two weeks in the absence of prominent mood symptoms. That criterion was not addressed explicitly in either evaluation. <u>Were the diagnoses made appropriate for the symptoms described?</u> There were occasions where the diagnosis made could be supported, but it did not account for the symptoms that were the focus of the psychiatric treatment. For example Individual #402 was appropriately diagnosed with pica. However, pica did not explain the symptoms that were the focus of psychiatric treatment, which were confusion, memory impairment and mood instability.	

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		Were NOS and r/o diagnoses appropriately excluded? The 20 evaluations reviewed included two individuals who had a primary diagnosis from the NOS category (Individual #402 and Individual #60, per the MPs for this medication), and Individual #197 had several r/o diagnoses that were made in February 2011; these were not addressed further as required by Appendix B. More broadly, among the 259 individuals supported by psychiatry, 29 individuals (11%) had NOS diagnoses. Twenty eight of these individuals had one NOS diagnosis, and one individual had two. Were the same diagnoses used for the same individual in a consistent manner? Usually yes, but there were exceptions. For example, Individual #60 had different diagnoses cited in the psychiatric evaluation, in his APL, and in MPs. Were the psychiatric needs properly evaluated and presented in a manner that allowed the broader PST to develop a PSP with action plans to address psychiatric issues that had been identified? In many cases the psychiatric formulations and diagnosis provided the PSP with information needed to best support the individual. In some cases this was not done. For example: • Individual #402: The Individual was known to have Down syndrome, and there had had been recent reports of confusion, memory impairment, and had been episodic mood instability, without agitation or belligerence. The individual was referred for psychiatric evaluation. On mental status examination (MSE) the Individual was reported to be calm and engaged, without psychomotor retardation or agitation, and no anxiety or depression was apparent. There had been no prior medication treatment. The individual was diagnosed with Depression, NOS. It is possible that depression NOS was the appropriate initial diagnosis for the reported symptoms, but there should have consideration of other diagnoses, for example dementia (which may or may not be related to Down syndrome). None of this is mentioned in the PSP, which simply stated that the individual was targeted for aggression. • Individual #417: The Individual was diagnosed with mood disorder secondary to general medical condition. Symptoms noted were screaming, crying, mood instability, and impulsivity (evidenced as aggression toward others, lower frustration tolerance and tantrum episodes to get what she needs). The symptoms were non-specific and presented diagnostic dilemmas. The psychiatrist's notes mentioned that seizure medication (was) changed from Tegretol to Keppra and the psychiatrist also added Topamax. The individual was reported to have had a worsening mood instability and impulsivity. Irritability can be a side effect of both Keppra and Topamax, and some consideration should have been made that drugs may have been related to the	

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		new-onset symptoms. • Individual #90: In the psychiatric evaluation, the individual was identified with metabolic syndrome and morbid obesity. This information was not sufficiently emphasized, was not included in integrated documents such as the PSP, and relevant action plans were not made.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	Of the 518 individuals who lived at the Facility, 259 received psychiatric care. Those individuals had all received comprehensive psychiatric evaluations (see provisions J2 and J6). The Facility reported that all other individuals had received Reiss screens as required. To confirm the negative screens reported by the Facility, the Monitoring Team selected a sample of 20% individuals for whom a negative screen was reported. This was done by selection of every 5th name from the list of individuals who lived at the Facility. If the selected name was of a person who was treated with psychotropic medication and for whom a Reiss screen was not required, the next name on the list was selected. Scores on both individual items and scoring sheets for categories were reviewed. Reiss Screens for Individuals #2, #45, #75, #83, #97, #121, #126, #136, #144, #169 #170 #190, #196, #208, #237, #252, #270, #304,, #320, #323, #329, #332, #367, #376, #394, #409, #416, #435, #437, #474, #499, #508, #519, #532, #534, #560, #566, #570, #581, #595, #608, #656, #657, #665, #670, #699, #701, #710, #727, #733, and #769 were requested, were received, and were reviewed. The Reiss screen for Individual #614 was requested but not provided. The Monitoring Team, having reviewed these following the visit, had questions about the screens for Individuals #45, #208, #304 #332, #367, #376, #508, and #581, and would like to review those screens with the Facility during the next visit. Regardless of these questions regarding 16% of the sample, it was clear that the Facility had met the requirements in this provision for screening and assessment.	Substantial 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	The Facility's approach to integrated behavioral healthcare was guided by DADS Policy and Procedures 007.2 Psychiatry Services (08/30/11). The section on integrated care clarified that *Each State Center must develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation*. The Monitoring Team examined several aspects of care: Interdisciplinary collaboration efforts: During the compliance visit the Monitoring Team	Noncompliance

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	formulation.	witnessed interdisciplinary collaboration efforts as follows: • Psychiatry clinic observations: The Monitoring Team observed two psychiatry clinics during the visit. These were conducted on 9/19/11 by Drs. Salam and Satpathy. Each clinic appointment was scheduled for 45 minutes and was attended by the individual, his/her psychologist, nurse case manager, QDDP, direct support staff members, and by both the psychiatrist and psychiatry assistant. Per routine the LAR/family members were welcomed to join the meetings (either in person or by telephone) and in one of the clinic visits attended, the LAR did so. The general format followed during the clinics was for the psychiatrist to interview/observe the individual, followed by reports from the psychologist, nurse and QDDP about their areas of clinical focus. Direct care professionals joined the conversation freely to provide their own thoughts and observations from the home setting. There was ample time during the clinic for the participants to discuss areas of mutual interest and they did so. The exchanges were substantive. The discussions during the clinic were clinically relevant and included meaningful exchanges of information and perspectives by the individuals and PST members. • Psychiatry clinic notes: PMR and QTR notes were reviewed for the 25 individuals in samples #1 and #2 and for Individuals #488 and #216, who were seen in the clinic on 09/19/11. As was the case during previous visits, the format of the note that the psychiatrist was a given was a prepared note (typically, three pages long) which provided information on the individual's DSM diagnosis, current psychiatric medications, graphs of behavioral data and a written paragraph on the recommendations and comments of the individual's psychologist. This information was also available to the psychiatrist prior to the meeting, to facilitate preparation as needed. During the clinic visit the psychiatrist filled in sections for the clinic note which were: o Interim History o Lab Results o Mental Status o Assessment As was the case during previous visits, the clinic notes were informed and detailed. During previous visits, the Monitoring Team had encouraged the Facility to develop better systems to (a) better identify the psychiatric symptoms that were the focus of medication treatments, (b) track those symptoms with behavioral data that will indicate whether or not the treatments are effective, and (c) present that data during the psychiatric clinics where decisions on medication treatment are typically made. The Facility has responded to these issues in a positive manner: In the past, clinic notes presented a single graph of behavioral data. The new format has two graphs: One presents a data summary of psychiatric symptoms, the other presents a data	

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		summary of targeted behaviors. For Individual #488, the psychiatric data assessed was "difficulty getting to sleep," "restless or agitated," and "rapid change in mood." For Individual #216, data items were "sleep and appetite disturbances," "weight loss," "crying spells," "loss of interest," "self-criticism," and "thoughts of death." The format and the content were adequate to be the basis for PST discussions on psychiatric issues that were data based. • Psychiatric Treatment Plans: Facility practice was to conduct/update psychiatric evaluations at least annually, using the SA-mandated Appendix B format, sections XIII (case formulation) and XIV (treatment recommendations). The Monitoring Team sampled 20 psychiatric evaluations, which are the focus of provision J6. As a general matter, all contained adequate treatment plans which were sufficiently detailed to provide psychiatric input for the combined case formulation discussed below. • Other Interventions and Disciplines: Psychiatrists were well integrated into the Facility Medical Department and worked side-by-side with somatic care medical providers in many settings, including Facility committees such as P&TC and polypharmacy. While PCPs did not always attend PTRs and QPRs, they participated in required treatment steps (see, for example, Provision J.10) by telephonic and individual conversations with the psychiatrists. Nurses were active collaborators and they participated in psychiatry clinics. Participation of other modalities of treatment (such as speech and language) was less evident in PST processes, although many times they are essential parts of an interdisciplinary treatment program. For example, during the PSP meeting for Individual #80 it was made clear that sensory modulation was an important part of his treatment program that was nonetheless informal and not incorporated into the overall behavioral healthcare plan. SA Provision J9 required consideration of "other interventions" and provision J10 required consideration of "alternative treatment strategies". Care provided by professionals from Speech and Language, PT and OT, is an important part of integrated behavioral healthcare and their role will be reviewed at the next visit. • The PBSP process: Previous reports of the Monitoring Team have emphasized that although there were many excellent clinicians in the Departments of Psychiatry and Psychology, there were problems in the flow of clinical information, so that the right information was brought together in the right venues and in the appropriate formats, in a manner that facilitated the development of integrated and cohesive behavioral health care programs. During the past six months the Facility made three decisions that address this matter positively: First, a decision was made to reformat the PBSP so the key psychiatric information regarding diagnosis and treatment was provided consistently in the PBSP.	

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		Information includes information on DSM IV diagnosis/diagnoses and information on all required elements of medication treatments, per DADS PBSP and SA requirements outlined in provision J9, J10, J13 and J14. The new format was implemented starting August 1, 2011. Second, a decision was made to try to include language that described the combined case formulation for the individual, as part of the PBSP. During the tour the Monitoring Team was presented with an example of the new PBSP, and a meeting was held, which included the two members of the Monitoring Team responsible for the areas of psychiatry and psychology, the Facility Lead Psychiatrist, and Chief Psychologists. The Monitoring Team members presented positive feedback to the Facility about the new format but also commented that the sample reviewed contained considerable side-by-side information from the different disciplines but could be improved by clarifying how the perspectives of the different disciplines were best combined/reconciled. Per discussion under Provision J2 of this report, there are some individuals at the Facility for whom the targets of behavioral and psychiatric treatment are the same. In such cases, the combined case formulation is an excellent place to clarify the thinking behind such concurrent treatment, for the particular individual. Third, the psychiatrists will start to sign the PBSP along with their colleagues from psychology, thus affirming that the PBSP is a shared core document that outlines an integrated behavioral healthcare program. • <u>The PSP process:</u> During the tour the Monitoring Team attended PSP meetings for Individuals #61 and #80, and PSPs for the 20 individuals in Sample #1 were reviewed. In both cases the PST psychiatrist attended the PSP. In each case the psychiatrist participated in the meeting and provided needed clinical psychiatric information. <u>Integration of treatment efforts between psychiatry and psychology:</u> The working relationships at the Facility between psychology and psychiatry were excellent, there was good expertise in both clinical departments, and psychiatry was a part of the treatment team. Nonetheless the Monitoring Team had identified in previous reports that the efforts of the two clinical departments were insufficiently integrated: Collaborative diagnoses occurred rarely, and there was a poor flow of clinical information/data to the appropriate clinical venues and to key enduring documents that guide treatment. This detracted from the overall quality of the treatment provided. The needed remedies for these issues were identified as a combination of work flow and work structure issues. The PBSP is now structured in way that encourages inclusion of key information from psychiatry as well as psychology (see above) and improvements	

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		are pending to improve information flow that will facilitate data based decision making (see below). <u>Coordination of behavioral and pharmacological treatment:</u> The introduction of MPs was a major step forward. The Monitoring Team reviewed 50 medication plans and found that 46/50 (92%) contained appropriate targets and most contained reasonable parameters for monitoring treatment efficacy. However, in many cases, medication plan details were not included in PBSPs, many of the Treatment Plans were not implemented, and designated data per MPs were neither collected nor reported (for details, see provision J13). Moreover, the graphing of data that were collected remains inadequate, in both the PBSPs and PMR/QPRs. There were two main problems: First, information on medication doses in the graph could not be readily compared to behavioral data, since these different variables were not provided on corresponding x axes (for time). Also, phase lines that indicated phase changes such as treatment initiation were rarely used. The above issues were discussed with the Chief Psychologist. The Monitoring Team understood that a new system has just been put in place and that it will take time to incorporate the needed elements. An additional challenge for data-based assessments of treatment effects was that baseline data on selected measures was not collected prior to the initiation of treatment, even when the medication trial was elective and the medication trial could have waited until after baseline measures were gathered. <u>Overall considerations:</u> The Monitoring Team has emphasized in previous reports that to improve integrated behavioral healthcare, there was a need to improve the selection and flow of clinical information to the key documents that outline treatment, and from there to the places where agreed treatment is implemented and reviewed. For psychiatry this means flow of information from the psychiatric clinics (run jointly with psychology) to the PBSP and PSP and from there back to the clinics and other treatment venues. Over the past 18 months the Monitoring Team has seen improvement in the PBSPs and PSP documents. As a result, the process of integrated treatment is more transparent and clear. The following examples illustrate advances and challenges in integrated treatment. For a number of individuals, the behavioral healthcare was integrated, and the joint behavioral formulation was presented well in the PSP. Examples were: • <u>Individual # 551:</u> This individual was recently admitted to the Facility after transfer from another facility. The diagnosis was reviewed, updated, and appropriate symptoms were identified for behavioral tracking. Following	

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		appropriate consultation between psychiatry and psychology staff, and with the involvement of the broader PST, a decision was made to reduce the Individual's medication, with careful tracking in place to monitor for reemergence of identified target symptoms. To date, the medication reductions were proceeding as planned and the Individual was doing well. The PSP was provided. • Individual #307: This individual had been diagnosed in the past with obsessive compulsive disorder. Following review, the diagnosis was changed to generalized anxiety disorder and psychiatric treatment was modified accordingly. The PBSP and the PSP contain good descriptions of the Individual's behavioral symptoms, and the manner in which medication and environmental interventions serve to reduce his symptoms and challenging behaviors. Sometimes, however, behavioral healthcare needed better coordination. For example: • Individual #119: The individual was admitted about one year ago for problems of severe emotional dysregulation with mood lability, anger, irritability, impulsivity, agitation, anxiety, depression, oppositional/antisocial behavior, poor frustration tolerance, and lack of coping skills. The individual's presentation was complex and required careful differential diagnosis and data-based interdisciplinary discussions. However, although psychiatric symptoms of impulsivity, aggression, mood lability and suicide gestures were identified in psychiatric clinic notes, no psychiatric symptoms were tracked until July 2011, making an otherwise excellent functional assessment done by psychology that month much less helpful. The process of evaluation and treatment was unacceptably slow, and the PSP suffered as a consequence. In other cases the PSP did not reflect an up to date understanding of the behavioral issues: • Individual #197: The individual was diagnosed several years ago with a thyroid disorder, and mood problems were understood to be associated with this condition. The individual was provided with medication treatments for the thyroid condition and for mood. The thyroid problem was corrected and the Individual's antidepressant was gradually tapered and now discontinued. These issues were not reflected in the PSP. It is possible that had the fuller information on behavioral healthcare been provided, action plan # 2 (creative leisure) and #3 (community outings) would have been written with more ambitious goals. • Individual #114: The individual has been diagnosed with IED for the past	

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		15 years, to reflect difficulties with physical aggression, property destruction and unauthorized departures. He was started on medications around the same time. Over the past two years, his two psychiatric medications were withdrawn; however, difficulties reemerged after several months. In May of 2011 his diagnosis was reevaluated, he was diagnosed with dysthymia due to chronic and recurrent patterns of withdrawal from social, recreational and training activities, refusal for self- care and healthcare needs, irritability, and appearing sad. The behavioral health care modified his treatment and added information, for example that the rates of target behaviors usually increase when he is ill or when he experiences an exacerbation of mood symptoms. The PSP was written in July 2011, and did not reflect the current overall understanding of the individual's behavioral healthcare needs and supports. In some cases, the PSP did not use fully use information in the behavioral healthcare formulation to best develop action plans: • Individual #587: The individual's PSP states "Medication and behavioral interventions were aimed at helping Individual to feel secure and reduce anxiety which leads to aggression when staff must redirect her. Much of her behavior plan is specifically focused on reducing her exposure to stressful events by increasing her opportunities to spend time outside. As anxiety and aggression decrease she will have more options for community placement." There were no specific plans in the PSP to follow-up on these observations. • Individual #19: Per the psychiatric evaluation, the individual could benefit from living at a group home in the community and less restrictive option has been discussed with guardian, and group home visits were suggested. Individual preferences were noted, along with an indication that the psychologist will be working on desensitization for dental appointments. The PSP mentioned only that the individual will continue to need psychiatric treatment and that there is no need for dental desensitization. • Individual #90: The individual was diagnosed with Schizoaffective disorder and treated with medications for psychosis and mood: The PBSP added that challenging behaviors occur sometimes during periods of unstructured activities, when attention is not focused on her, and when she is in an environment that she does not wish to be in. This information was helpful both to the understanding of the Individual and to habilitative care. However, the PSP stated only that the Individual has the diagnosis of schizoaffective disorder and has a PBSP.	

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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.	Records from Samples #1 and #2 were reviewed for this provision. Materials reviewed included PBSPs, PSPs, PMRs, and QPRs. The Monitoring Team examined how PSTs determined which behavioral healthcare treatments were needed to support individuals. Discussions on these matters took place in various PST meetings that were attended by behavioral healthcare professionals (typically psychiatry and psychology), professionals from the broader healthcare team (typically nursing, pharmacy, and sometimes the PCP), the Qualified Developmental Disability Professional (QDDP), the broader PST, and the individual whose care was reviewed. Discussion also took place during annual PSP meetings. LARs and guardians were welcomed to participate in these meetings, either by attending in person, or via telephones with speakerphone capabilities. Psychiatrists were actively involved in the PST process. As described under provision J3, psychiatrists were active participants in all PMRs and QPRs, and a positive process was observed during the visit in psychiatry clinic appointments for Individuals #216 and #488. The Monitoring Team also attended the PSP annual meetings for Individuals # 61 and #80. Psychiatrists attended the meetings and contributed to the discussion. The Facility has recently decided that psychiatrists will sign PBSPs, to reflect their active participation in their creation. The Monitoring Team examined each of the three core requirements of provision J9, as follows: 1. <u>Least intrusive and most positive interventions.</u> All 24 PBSPs reviewed by the Monitoring Team contained explicit language that described efforts to use less restrictive practices. This was typically included in a PBSP section with the related title of "Attempts at Less Restrictive Practices." Relevant descriptions were found in 22 of 24 PBSPs (92%). The PBSP for Individual #171 had an "Attempts at Less Restrictive Practices" section but it was not informative. The section for Individual #386 was missing. There were some cases where most positive practices were cited. For example, for Individual #417 the PBSP stated "the following interventions were attempted behaviorally; positive reinforcement and incentive program, environmental engineering, and breathing exercise as a replacement behavior." 2. <u>Individuals served primarily through behavioral, pharmacology, or other interventions, in combination or alone</u>: In each PBSP and in PSPs, the Monitoring Team found descriptions of the treatments that were provided but explicit statements about which treatments were selected and why were not found. A typical example was for Individual #587, whose PSP stated: *"Medication and behavioral interventions are aimed at helping (the Individual) feel secure and reduce her anxiety which leads to aggression when staff must redirect her.*	Noncompliance

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		Much of her behavior plan is specifically focused on reducing her exposure to stressful events by increasing her opportunities to spend time outside. As anxiety and aggression decrease she will have more options in the community." This statement had many positive elements. It included an integrated understanding of the roles of medication and behavioral interventions, and it helped establish how the individual might progress toward a less restrictive and community-based home. However, it did not explicitly state that the PST had determined that both modalities of treatment were needed, and why, nor did it make clear that such a discussion had taken place. It is quite possible that a discussion <u>had</u> taken place and that the result was that the PST determined that both medication and behavioral interventions were determined to be helpful, since the individual had an anxiety disorder, medication reduced her levels of anxiety, and behavioral interventions reduced her exposure to avoidable stress. If that were the case, the PSP would have been improved had it said so. "Other interventions" were not explicitly mentioned in the PBSP. In the case of Individual #80, whose PSP was attended by the Monitoring Team, an occupational therapist who was present described that the individual, who was diagnosed with autism, benefited from use of a "sensory diet." That is an example of "other interventions" which should be included in the discussion of modalities of treatment that were offered to the individual. <u>Non-pharmacological treatments, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible</u>. With the exception of Individual #743 whose circumstances were reviewed under provision J3, all individuals reviewed who received psychotropic medications had non-pharmacological supports in place.	
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	Records from Samples #1 and #2 were reviewed for this provision. Materials reviewed included MPs, ICs, PBSPs, PSPs, PMRs, and PQRs. Risk analyses were contained in two places: 1. PBSPs all contained "risk vs. risk" sections. However PBSPs were not explicit about the participation of the required medical personnel in the risk determination identified by the provision. 2. Psychiatrists wrote risk-benefit analyses that were part of the format for MPs (see also provision J13). The MPs were developed before the non-emergency administration of medications. The MP form was filled out by the psychiatrist during PMR/QPR meetings. Participants in the PMR typically included the nurse, although sometimes not the PCP. When the PCP was not present, the	Substantial Compliance

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	medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	psychiatrist called the PCP, discussed the relevant issues, and documented the discussion on the IC form. The Monitoring Team reviewed 50 MPs for the 25 individuals who were part of Samples #1 and #2, and all MPs contained a risk/benefit section. <u>Medication Risk:</u> All MPs indicated that risk associated with the medication were side effects of the medication. Some MPs were more detailed than others regarding the level of detail with which particular side effects were listed. This matter was discussed with the Lead Psychiatrist, who indicated that there had been a change in the manner the side effects were listed. Prior to 07/01/2011 side effects that were particularly pertinent to the individual were listed in the IC form. After 07/01/2011 the pertinent side effects were listed on both the IC and MP forms. Many of the MP forms that were reviewed listed the specific side effects information (for example MPs for Individuals #306, #451, #530, #386, and #119). Some MPs contained only a general statement, for example that the nurse case manager would monitor for side effects from psychotropic medications (Individual #551). <u>Medication Benefits:</u> All MPs stated that the benefits outweighed the risks, but the level of detail with which the potential benefits were described varied considerably. In some cases there was considerable detail. For example: *"The individual is prescribed Lexapro to treat mood/depressive symptoms. Depressive symptoms affect (the Individual's) life as follows: 1. Refusal of treatment (especially O2) and self-care hygiene carry significant consequences due to his health problems. 2. Aggression poses a safety risk for other and for himself (due to retaliation from others) and 3. Disturbed mood agitation and noncompliance impair his ability to participate in social and recreational activities* (Individual #114)*."* In some plans benefits presented were less detailed, but the information was still adequate. For example: *"Benefits of mood stability outweigh risks of named side effects* " (Individual #530)*.* Rarely, possible benefits were listed only as "symptom control" (Individual #402, MP for Lexapro). Such descriptions were too broad to meet the SA requirements for provisions J10, J13 and J14. <u>Treatment Alternatives:</u> Some MPs described that the psychiatrist had discussed treatment alternatives. For example, MPs for Individual #587 (Seroquel and Remeron), for Individual #60 (Lexapro) and for Individual #372 (Lunesta and Rozeram). The presentations did not include any details, and other MPs did not contain references to treatment alternatives. Accordingly, the presentation of treatment alternatives needs to improve.	

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		With the MPs in place, the Facility had a good format and good process for discussion of risks, benefits, and alternatives. The Monitoring Team will review this area during the next tour for consistent presentation of pertinent side effects and for discussion of treatment alternatives.	
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.	Materials 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, minutes of the PRC and P&TC for the period between March 2011 and August 2011, information on polypharmacy presented in QDRRs for individuals from Samples #1 and #2, and observations made by the Monitoring Team during the September PRC and P&TC meetings. Information received prior to the visit and which included the PMOC data for July 2011 indicated that there were 253 individuals at the Facility who were treated with psychotropic medications. Of these, 13 individuals had intraclass polypharmacy and 67 had interclass polypharmacy. There were 5 individuals who had both intraclass and interclass polypharmacy, per SA definitions of each. Overall, there were 75 individuals who were treated with polypharmacy. This was 30% of the individuals who were treated with psychiatric medications at the Facility. The Facility continued to conduct monthly PRC meeting. Clinicians attended the meetings from psychology, psychiatry, medicine and nursing, and representatives from pharmacy. The monthly meeting for September 2011 took place during the visit, and the Monitoring Team attended the meeting. The format for the monthly review was that individuals who receive intra-class polypharmacy (currently thirteen individuals) were reviewed monthly. The format was that attending psychiatrists were provided an update on individuals' status, backed when possible by data. Additionally, PRC reviewed individuals who received interclass polypharmacy, starting with individuals who took five or more medications, followed by a review of individuals who took four or more medications, etc. As of September, the committee had reviewed individuals who took three or more medications. The Monitoring Team asked the Pharmacy Director about the expected time that it would take to review all individuals with interclass polypharmacy, and the estimate was for a cycle of about one year. Periodically, the committee also reviewed pharmacy data regarding Facility use of a medication or class of medication. During the September 11 meeting, Facility- wide use of benzodiazapines was reviewed. During the visit the Monitoring Team attended the P&TC meeting for September 2011 and received a report regarding polypharmacy trends over the past several years:	Substantial Compliance

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		Intraclass polypharmacy declined from 21 individuals (09/09), to 17 individuals (09/10), and most recently to 11 individuals (08/11). Interclass polypharmacy declined as follows: For five or more drugs, from 9 individuals (09/09) to 3 individuals (08/11); for four or more drugs from 26 individuals (09/09) to 16 (08/11); for three or more drugs, from 54 (09/09) to 46 individuals. Review of the monthly figures showed that the declines were gradual and sustained. The slight differences between these data and PMOC data cited above reflect additional decreases in polypharmacy between July and August 2011. Overall, the Monitoring Team found that review of polypharmacy continued to be detailed and substantive, at the individual level via the QDRR, in discussion that followed in the PMR (see provisions J2 and J3), and in the monthly reviews described above.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	Information reviewed for this provision was from Sample #1. Clinical materials reviewed included annual medical summaries, active problem lists, most recent health risk assessments, 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 previous tour of the Monitoring Team and had not changed. MOSES and DISCUS forms were reviewed for the nineteen individuals in Sample #1 who took psychotropic medications. Sixteen of these individuals took medications that required DISCUS evaluation for tardive dyskinesia. The Monitoring Team found that for six of the nineteen individuals (31%), the MOSES forms were not signed by the psychiatrist. For three of the sixteen individuals who received DISCUS evaluations, the forms were not signed by the psychiatrist. At the last compliance visit, MOSES and DISCUS forms sampled had been properly completed, and this provision was found to be in substantial compliance. Because of the lack of signatures to substantiate review by psychiatrists found in the current sample, this provision is not in compliance at this time. To regain compliance, the Facility will need to ensure that psychiatrists review these assessments, substantiate the reviews by signing the assessment forms, and respond to the findings of the assessments as needed.	Noncompliance
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	The records of the 25 individuals in Samples #1 and #2 were reviewed. For each individual, the Monitoring Team examined psychotropic medication plans, most recent PBSPs, psychiatric evaluations, and recent PMR/PQRs (three for individuals in the case of Sample #1, one for individuals in Sample #2). As described in the March 2011 compliance report and in the Facility POI, each time a	Noncompliance

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	psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	new medication was proposed by the psychiatrist, a MP form was completed. MPs were also completed by the psychiatrist at the time of annual psychiatric evaluation of the individual that was done prior to annual PSP meetings. Whenever a medication plan was written, the psychiatrist also completed an IC for the medication, which was reviewed and signed by the individual's LAR/guardian. LAR/guardians were provided with copies of both the MP and IC. The contents of the MPs are reviewed in the paragraphs that follow, and the ICs are reviewed under provision J14. Each MP contained • Name of the medication • Psychiatric Diagnosis • Rationale for the treatment • Target psychiatric symptoms • Symptoms to be monitored • Timeline for expected results • Risk/Benefit Assessment MPs and ICs were reviewed by BSRC and HRC, along with an updated PBSP that had been updated to contain the information about the new medication that was included in MPs and ICs. PBSP sections that were updated included information about the name of the medication and associated information, such as possible side effects and the psychiatric symptoms to be monitored to determine treatment efficacy. PST psychologists also updated the data section for psychiatric symptoms that included a graph of the combined psychiatric symptoms to be monitored for all psychiatric medications that the individual received. The same information was subsequently brought to the psychiatric clinics (PMR/QPRs) along with updated data, in order to provide ongoing monitoring of medication treatment efficacy. The Monitoring Team reviewed fifty medication plans written for individuals from Samples #1 and #2. All were written during the past 12 months. The Monitoring Team found as follows: • <u>Information on medication and diagnosis:</u> MPs contained both the name of the medication and the psychiatric diagnosis that was related to the medication. In all cases, the diagnosis named was one of the diagnoses listed in the Facility wide list of individuals' current DSM IV psychiatric diagnoses. In turn, all of those diagnoses corresponded with the most recent psychiatric evaluation for the individual, updated as necessary via the diagnostic update process (see provision J.2). • <u>Rationale for the treatment:</u> The purpose of this section was to clarify why the particular medication was proposed, in the context of the individual's overall	

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		treatment. Many times, the rationale was self-evident, for example in the initial treatment for depression with a medication that was FDA approved for use as an antidepressant. In other cases, the rationale for the use of the medication needed some explanation, as for example if the use of the medication was "off label" or when the reason that the new medication was introduced was related to particular circumstances in the individual's treatment. In most cases, the rationale was appropriately presented with one or two sentences. Rarely was the rationale not sufficient. For example, for Individual #494 the rationale for the use of the medication Saphris was to see if the patient would benefit from the medication. Elsewhere on the MP, the target symptoms of delusions and hallucinations were identified, and the individual was already treated with another antipsychotic medication. It seemed likely that new medication was added since the antipsychotic treatment in place had not provided adequate symptom relief. If so, that should have been the stated rationale. • Target psychiatric symptoms: The Monitoring Team examined the list of target symptoms to make sure that at least one of the targets was clearly related to the psychiatric diagnosis listed in the MP. The psychiatric targets of treatment were typically broad categories of symptoms, such as delusions, depression and so forth. In a majority of the cases (46/50 or 92%) the Monitoring Team found that the psychiatrist had indeed listed at least one target symptom that met the criterion. Rarely, the Monitoring Team did not find appropriate target symptoms. For example, for Individual #637 (MP for Neurontin, diagnosis of major depression) the cited targets were agitation and aggression, which are not core symptoms of Major Depressive Disorder. • Symptoms to be monitored: The MPs provided particular behavioral characteristics of the psychiatric disorder that were selected as markers of possible treatment response. The method selected by the Facility for symptoms assessment was for the PST psychologist and psychiatrist to choose appropriate symptoms for monitoring. The Facility did not use standardized rating scales, although the Monitoring Team was informed that many of the items selected were part of DASH II subscales. Likert scales for ratings were constructed and the psychologist then rated the individual for those symptoms on a weekly basis. The rating was determined based on personal observation by the psychologist and based on information provided to the psychologist by DSPs and other staff members. During the next tour the Monitoring team will review examples of the symptom assessment method selected by the Facility. • Timeline for expected results: The MPs all contained an estimate for the onset of treatment effects. • Risk-Benefit analyses. All MPs contained risk-benefit presentations. These were discussed under provision J.10.	

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		The Monitoring Team examined the MPs to see how well they were incorporated into PBSPs. For each of the individuals, the Monitoring Team examined the most recent PBSP. Each medication mentioned in the PBSP was compared to the MP for that medication. Forty medications were examined, as follows: • Were the symptoms listed in the MPs included in the PBSPs in the descriptions of the relevant medications? In most cases, some of the symptoms were mentioned, but in many cases there were differences, often significant, between the symptoms listed in the medication plan and what was mentioned in the PBSP. Examples were Individuals #50, #171, #, and #587. On some occasions the medication plan did not provide specific symptoms (for example, MP for Individual #240 listed symptoms as "monitor quarterly psychiatric assessment"). • Did the PBSP have separate data sections for psychiatric symptoms and targets for psychology? Six PBSPs had two data sections, per the current PBSP, and 19 did not. • If there was a psychiatry data section, did it list symptoms per the medication plans? Of the six PBSPs that had separate data sections, only two (for Individuals #197 and #417) listed the symptoms that were listed on MPs. • Did the Behavioral data section contain data listed on the MP? In some cases (for example, Individual #372) psychiatric data was recorded in the behavioral data section, not the psychiatric data section. The Monitoring Team also examined the most recent psychiatric clinic note (PMR or QPR) to examine whether data on the selected psychiatric symptoms was reported for review. Results were as follows: • Did the PMR/QPR have separate data sections for psychiatric symptoms and target for psychology ? Some PMR/QPRs (for example, Individuals #587 and #637) did but in other cases the new format was not yet in place. • Did the section for psychiatric symptoms report data? The format for presenting psychiatric data had just been put in place and sometimes (example – Individual #119) there was no data in place. Overall, the Facility has developed a credible method to respond to the requirements of provision J13 specifically, and more generally to the requirements of provisions J3, J8 and J9. Implementation was in its early stages.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year,	Samples #1 and #2 were reviewed for this provision. Documents reviewed were the ICs for psychotropic medications, MPs for those medications, and the individual's most recent PBSP. Forty medications were reviewed.	Noncompliance

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	each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	In the 09-07-11 Plan of Improvement, the Facility reported correctly that as of 07-01-11 the Psychiatry Department completed Psychotropic Medication Consent Forms according to the recommendations from the last compliance visit. Changes made included inclusion of initials or signatures that indicated who the persons were who obtained telephonic consent. The consent form now in use provided the following information: 1) Diagnosis 2) Medication for approval and medication dose ordered 3) Recommendations from consulting psychiatrist (if applicable) 4) Pertinent side effects (discussed with guardian/director) The consent form had a box for signature by the prescribing physician (which in all cases was the psychiatrist) and a box for the psychiatrist to document the date/time for the discussion between the psychiatrist and the PSP. A general indication was provided on the form in which the guardian/LAR acknowledged that explanations about the medication were given in simple, nontechnical language and included: 5) A description of any benefits to be expected 6) Disclosure of any appropriate alternative procedures that might be advantageous to the person served as well as the potential risks and benefits associated with those alternatives 7) Possible adverse side effects/risk of the prescribed medication, per drug effect monographs provided to the guardian The medication consent form clarified that the consent was valid for a period of no longer than one year, and called for designation of the expiration date. The form also clarified that the LAR/Guardian could revoke the consent. The process by which the consent process was obtained was reviewed with the Lead Psychiatrist. Non-emergency medications were discussed during PMRs/QPRs, Plans for use of the medication were developed, discussions about risk benefit, common side effects, rationale for the use of the medication and the targets addressed by the medication were identified, and alternative treatments were discussed. The psychiatrist next contacted the LAR/Guardian to provide the information about the medication that is described above, and to be available to the LAR/Guardian to discuss any needed aspects of care. The PCP was also a required part of the process (for example, see provision J.10). In discussions during the visit, the Lead Psychiatrist clarified that as a matter of clinical quality, PCPs now often attended PMR's/QPRs, but their participation	

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		could not be guaranteed. If the PCP was not present, the psychiatrist called the PCP to discuss details and documented that the conversation had taken place (and any specific recommendations that resulted) on the consent form. The form was then mailed to the LAR/Guardian, and was then forwarded to PBRC and HRC for review, together with the new medication plan and a PBSP, now revised to include the information on the new medication. The psychiatrist did not write orders to start the new medication until consent (verbal or written) was obtained. During the visit, the Monitoring Team reviewed the Informed Consent Form and review process with the Lead Psychiatrist. During the discussion the Monitoring Team noted the consent form provided assurances that items (5) and (6) were reviewed with the guardian, but the form provided only a general statement and did not include needed details. However, these details were properly included in the Medication Treatment Plan that accompanied the consent. The Facility agreed that it would be good practice to send the Guardian/LAR both the consent form and the medication plan (for related comments, see provision J.13). Review of the 40 medication consents were as follows: Identification of Medication Side Effects: Pertinent medication side effects were listed on all 40 medication consents. However, there were relatively few cases in which the same side effects were listed on the medication consent form and in the PBSP subsequently reviewed by PBRC and HRC. For eight medications, the same information was listed for medications on ICs and PBSPs; examples included Individual #530, Individual #587 (for Seroquel, Restoril and Trileptal) and Individual #372 (for Lunesta). For 21 medications, different information was provided for side effects on the consent form and the PBSP. Examples were Individuals #50, #637 and #606. In the case of Individual #606, an additional problem was that a single list of side effects for all medications was provided, instead of a separate list for each medication. For 12 medications, side effects of medication were not provided in PBSPs. Examples included medication in PBSPs for Individuals # 317, #606, and #114. The previous version of the PBSP was unclear about how medication side effects information should be reported. The instructions for the new format (effective 08/01/11) make clear that side effects from medication should be listed, and specify where in the format they should appear. In the IC, the psychiatrist highlighted to the LAR/guardian which common side effects were particularly relevant to the individual based on that individual's health care status, past experience, and so forth. That individualized list of side effects notification is on the IC form, and it is those side effects that should be highlighted in the PBSP. In addition, the current IC form states that in addition to the individualized list of possible side effects, a drug information monograph should be sent to the guardian. Such monographs contained more extensive information	

#	Provision	Assessment of Status	Compliance
		and need not be cited in the PBSP verbatim. Medication dose: The initial dose of the medication was listed in many ICs but not all. The dose range for the proposed use of the medication was not listed on MPs. Both were needed. PCP participation in decision-making: All ICs documented that the PCP participated in the discussion about the medication, either telephonically or in person. When the participation was via telephone consultation the IC documented with whom the discussion took place. In all ICs reviewed, it was the psychiatrist. Time and date of the participation were provided in all cases. LAR/Guardian signature was present in all cases, and included time and date. When (witnessed) verbal consent was obtained, it was followed up with written consent.	
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, the list of psychotropic medication per the psychiatry department's Facility Information Sheet (FIS), and minutes of neurology clinics for March, April, June and July 2011 that were attended by psychiatrists. 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 the scheduled on-site neurology clinics. The conference length varied but was typically about an hour. The neurologist, one of the psychiatrists, the neurology clinic coordinator and one of the psychiatry assistants, attended it. 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 Monitoring Team was informed that they did so. The Monitoring Team reviewed the notes taken by the psychiatry assistant and the recommendations made for each of the individuals in Sample #4, who had been seen in the neurology clinic and were supported by both psychiatry and neurology.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Notes relevant to both disciplines were noted in all cases. In the case of three individuals, psychiatrists consulted with the neurologist about medications that were prescribed for behavioral indications, (for example Depakote and Klonopin), but could also have effects on individuals' concurrent neurological conditions such as epilepsy. The consultations and recommendations were useful and appropriate. There were 16 cases where clinic notes described medications as "dual purpose." These were medications prescribed for both epilepsy and a behavioral indication. The medications were compared to two reference lists: The list of all psychiatric medications that was maintained by the Department of Psychiatry, and the list of dual purpose medications that was maintained by the pharmacy. Each of these medications should have been included on both lists. However, three of the medications (Tegretol for Individual #313, Depakote for Individual #489, and Depakote for Individual #539) were not included on the psychiatry list. Six of the medications (Depakote and Tegretol for Individual #313, Depakote for Individual #489, Depakote and Neurontin for Individual #539, and Depakote for Individual #616) were not included in the pharmacy list. The Facility should review the lists for accuracy. The above issue notwithstanding, on the basis of the overall examination of the records, discussion with the psychiatrists, and observations made at the time of the visit, the Monitoring Team found that coordination between psychiatry and neurology 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. Psychiatric data reported in PBSPs and psychiatric clinic notes (PMRs and QPRs) should reflect the symptoms identified in MPs. (Provisions J3, J8, and J13)
2. Graphic presentation of psychiatric data in PBSPs, PMRs and QPRs should improve to reflect generally accepted professional standards. (Provisions J3, J8 and J13)
3. Physicians should review and sign MOSES and DISCUS side effect screens (Provision J12)

The following are offered as additional suggestions to the Facility:

1. The Facility should review for accuracy the tracking of anticonvulsant medication which are prescribed for both psychiatric and neurological indications. (Provision J15).

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. DSSLC Plan of Improvement (POI), dated 9/7/2011 2. DSSLC Presentation Book for Section K 3. Counseling Policies and Procedures (12/01/2010) 4. Behavior Services Peer Review Committee meetings minutes (2/9/2011 – 7/27/2011) 5. Behavior Service departmental meetings minutes (3/24/2011 – 07/22/2011) 6. Preliminary materials for Competency-Based Training from Behavior Services department 7. Documents that were reviewed included the annual PSP, PSP updates, Specific 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 Individuals #12, #035, #050, #504, #709, #119, #127, #148, #163, #168, #181, #182, #195, #217, #229, #287, #297, #306, #334, #336, #337, #349, #352, #381, #445, #482, #526, #533, #551, #585, #590, #624, #627, #703, and #778 **People Interviewed:** 1. Randy Spence, MS – Director of Behavior Services 2. Jill Wooten, MS, BCBA – Psychologist 3. Katy Acheson, MS, BCBA – Contract Psychologist 4. Brian Almejo, MS – Psychologist 5. Denney, Dale, M.Ed., LPC-S – Psychologist 6. Candy Mathers, MS – Psychologist 7. Robert Schecter, MS, LPC – Psychologist 8. Kristen Skousgard, MA, BCBA – Psychologist 9. Janet Waggoner, MS, LPC-I – Psychologist 10. Linda Ford – Director of Active Treatment 11. Approximately 30 direct care staff **Meeting Attended/Observations:** 1. At Risk Meetings (9/20/2011 and 9/22/2011) 2. Psychology/Psychiatry Meeting (9/20/2011) 3. Positive Behavior Support Committee (9/21/2011) 4. Restraint Reduction Committee – (9/21/2011) 5. External Peer Review (9/22/2011) 6. Human Rights Committee (9/22/2011) 7. Observed residences and classrooms on 512s (9/21/2011) 8. Observed vocational settings and classrooms (9/21/2011) 9. Observed residences on 522s (9/21/2011) 10. Observed residences on 508s, 522s, 524s and 528s (9/22/2011)

	Facility Self-Assessment: At the time of the site visit, DSSLC reported that Provisions K.3, K.5, and K.8 were in substantial compliance with the SA. The Monitor was in agreement with the Facility in relation to Provision K.3, as documentation clearly reflected a comprehensive and effective peer review process. The Monitor also agreed that several elements of Provision K.5 reflected considerable improvement. However, the requirement related to intellectual and adaptive assessment remained substantially unaddressed in the records reviewed. In relation to Provision K.8, although the Facility had invested considerable effort into the development and implementation of a system of counseling services, those services did not conform to expectations of evidence-based practice required by the SA.
	Summary of Monitor's Assessment: Observations, interviews and record reviews were conducted on-site at DSSLC from 9/19/2011 through 9/23/2011. Record reviews continued off-site for several days following the site visit. Only one Provision of the SA, Provision K.3 was found to be in substantial compliance. It was noted, however, 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 in relation to Provision K. As noted, the Facility achieved Substantial Compliance with Provision K.3. DSSLC was able to demonstrate that both an internal and external peer review process was in place. Furthermore, the evidence reflected that the peer review process was capable of producing improvement in the PBSPs and behavior assessments. This reflected considerable improvement over the past two years. It is anticipated by the Monitoring Team that this achievement will provide an enhanced ability to move toward compliance with other elements of Provision K. The Facility also demonstrated continued improvement in acquiring and maintaining staff who were demonstrably competent in applied behavior analysis. The number of Board Certified Behavior Analysts employed by DSSLC had increased, and the percentage of the staff enrolled in BCBA coursework remained high. Efforts to collect treatment data had substantially improved in comparison with the baseline site visit. Data for both target and replacement behaviors were included in the data collection process. In addition, the Facility had continued to expand the number and location of interobserver agreement observations. A substantial limitation remained, however, in that symptoms of mental illness were not well integrated into the data collection process. Furthermore, data graphs did not frequently reflect measures of mental illness. Functional assessment of behavior had also continued to improve. In many areas, the functional assessments completed by the Facility were approaching the level of substantial compliance. At least two important areas regarding functional assessment continued, however, to reflect substantial limitations. The assessment process did not integrate the assessment of mental illness into the functional assessment. Although substantial documentation of the assessment and treatment by the psychiatrist was often

	included, this information served only to document a parallel process rather than a process that contributed to the functional assessment. Additionally, the functional assessments reviewed did not clearly identify replacement behaviors that served the same function as the behavior targeted for reduction. The Facility had also greatly expanded the efforts to provide interventions other than behavior analytic programs to people living at DSSLC. The personnel tasked with providing these services, in most cases counseling, were knowledgeable, enthusiastic, and dedicated to the task. In many of the interventions reviewed; however, there was a lack of evidence-based approaches in the intervention process. Overall, although the Facility had demonstrated effort to improve the quality of services, and in many circumstances demonstrated considerable progress, a sizable amount of work remained before substantial compliance could be achieved.

<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 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>At the time of the current site visit, DSSLC demonstrated minimal improvement in ensuring that the PBSPs were developed by staff with demonstrable competence in applied behavior analysis. In September 2010, the first site visit when data were available, 13 of the 224 PBSPs (14%) developed in the previous six months were developed by a BCBA. At the time of the current site visit, data reflected that 21 of 121 PBSPs (17%) developed in the previous six months were developed by a BCBA.
<table>
<tr><td></td><td>9/2010</td><td>9/2011</td><td>Change</td></tr>
<tr><td>Total number of PBSPs implemented since previous site visit</td><td>224</td><td>121</td><td></td></tr>
<tr><td>Total percent of PBSPs developed by a BCBA implemented since previous site visit</td><td>14%</td><td>17%</td><td>3%</td></tr>
</table>
Although not reflected by the involvement of BCBA in the PBSP development process, DSSLC did demonstrate progress in increasing the number of staff who possessed board certification in applied behavior analysis. During the initial site visit in March 2010, the Behavior Services department employed 17 professionals who were eligible to pursue a BCBA: four of those employees were BCBAs. At the time of the current site visit, the Behavior Service department had grown to include 20 staff eligible to pursue board certification, with seven employees having earned board certification. Those seven BCBAs comprised 35% of the department, an increase of 9%.
<table>
<tr><td></td><td>3/2010</td><td>9/2011</td><td>Change</td></tr>
<tr><td>Staff eligible to pursue board certification</td><td>17</td><td>20</td><td>3</td></tr>
<tr><td>Total number of BCBAs</td><td>4</td><td>7</td><td>3</td></tr>
</table></td><td>Noncompliance</td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
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<tr><td>Total staff enrolled in BCBA classes</td><td>4</td><td>11</td><td>7</td></tr>
<tr><td>Percent of BCBAs</td><td>24%</td><td>35%</td><td>11%</td></tr>
<tr><td>Percent of staff enrolled in BCBA classes</td><td>23%</td><td>85%</td><td>62%</td></tr>
</table>

Of the 13 Behavior Service staff who were not board certified, 11 were actively participating in classes or supervision required for board certification: four were scheduled to sit for the board certification examination shortly after the current site visit. These data reflected that DSSLC had acted diligently and aggressively toward employing BCBAs. Although the total number of BCBAs had increased only modestly, DSSLC had substantially increased the number of Behavior Service staff pursuing board certification in applied behavior analysis. Despite this progress, however, DSSLC had not taken the steps necessary thus far to ensure that behavior interventions were developed by persons with board certification in applied behavior analysis.</td><td></td></tr>
<tr><td>K2</td><td>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.</td><td>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 was, at the time of the site visit, scheduled to sit for the BCBA board certification exam. When he has earned board certification, his role as Director of Behavior Services will be in full compliance.</td><td>Noncompliance</td></tr>
<tr><td>K3</td><td>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.</td><td>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.

External peer review was 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</td><td>Substantial Compliance</td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>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 first six months of the external peer review process is presented below.

<table>
<tr><th>Area of Competency</th><th>Percentage Achieved 9/2010</th><th>Percentage Achieved 9/2011</th><th>Change</th></tr>
<tr><td>Competency 1</td><td>78</td><td>88</td><td>10</td></tr>
<tr><td>Competency 2</td><td>50</td><td>72</td><td>22</td></tr>
<tr><td>Competency 3</td><td>75</td><td>87</td><td>12</td></tr>
<tr><td>Competency 4</td><td>52</td><td>80</td><td>28</td></tr>
<tr><td>Competency 5</td><td>51</td><td>76</td><td>25</td></tr>
<tr><td>Competency 6</td><td>35</td><td>42</td><td>7</td></tr>
<tr><td>Competency 7</td><td>33</td><td>63</td><td>30</td></tr>
<tr><td>Competency 8</td><td>78</td><td>93</td><td>15</td></tr>
<tr><td>Total of all Competencies</td><td>55</td><td>75</td><td>20</td></tr>
</table>

Based upon this comparison, training and review practices had been enhanced, and behavior assessments and interventions were improved. Although there were areas in which the PBSPs did not yet meet substantial compliance with the SA, the peer review process was effective in improving the PBSPs. Based upon the data obtained during the most recent site visit, peer review was successful in meeting substantial compliance with the SA.</td><td></td></tr>
<tr><td>K4</td><td>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</td><td>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 that used a standard form for recording data. This form was designed to 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.</td><td>Noncompliance</td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.</td><td>At the time of the current site visit, the Behavior Services department reported that the data collection process had not been further revised. As a result, the concerns regarding data collection for low- and high-frequency behaviors continued. A review of 12 PBSPs and the associated data, however, revealed substantial improvement in many areas over the baseline site visit. One area where data collection reflected substantial limitations was in the graphic presentation of interobserver agreement (IOA) data. None of the data graphs reviewed included IOA data.

<table>
<tr><th></th><th>Baseline</th><th>9/2011</th><th>Change</th></tr>
<tr><td>Targeted behavior data collection sufficient to assess progress.</td><td>0%</td><td>82%</td><td>82%</td></tr>
<tr><td>Replacement behavior data collection sufficient to assess progress.</td><td>0%</td><td>73%</td><td>73%</td></tr>
<tr><td>Data reliability is assessed.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Target behaviors analyzed individually.</td><td>0%</td><td>82%</td><td>82%</td></tr>
<tr><td>Targeted behaviors graphed sufficient for decision-making.</td><td>60%</td><td>82%</td><td>22%</td></tr>
<tr><td>Replacement behaviors graphed sufficient for decision-making.</td><td>0%</td><td>91%</td><td>91%</td></tr>
</table>

A limitation was also noted in data collection regarding mental illness. In a review of the 12 most recent PBSPs, treatment targets associated with the symptoms of a mental illness were often measured by means of a non-standardized rating scale using Likert-type items. Regardless of whether the target involves learned behavior or a symptom of a mental illness, it is crucial that measurement of the target be as precise and sensitive as possible. Targets being measured should be defined in observable and measurable terms, the measurement practices should reflect validity and reliability, and the frequency of measurement should be sufficient to capture an adequate number of displays of the target being measured. This can be especially important in regard to targets involving psychotropic interventions, as those pharmacologic agents often are associated with undesired and potentially harmful side effects. Non-standardized rating scales often lack the precision necessary to adequately assess treatment response. As a result, a poor response to treatment may be missed by the rating scale and the psychotropic medication continued unnecessarily.

An additional limitation that had the potential to impair the treatment assessment process was the lack of comprehensive and specific treatment expectations. The majority</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		of the reviewed PBSPs included a goal for determining success, often the elimination of the treatment target within a span of several months. This was problematic in that a PBSP producing minimal benefit could be continued for several months before the need for revision was required. A related issue was that none of the reviewed PBSPs included expectations or criteria for failure. In other words, there were no criteria, prior to the "success" target date, to indicate that an intervention was ineffective or counterproductive. Due to both issues, the PST or treating professional was not provided a guide for when to review and revise ineffective interventions. Although the PBSPs reviewed for this Section were in the new format and had not been in place long enough for the need for revision to become evident, PBSPs reviewed for Provision C.7 typically were revised at the time of the annual PSP even though restraint use would indicate a need for review at other times. • For Individual #526, treatment expectations were that, "Episodes of SIB will be reduced to 40 or fewer episodes per month for 6 consecutive months by 06/02/2012." According to these guidelines, there were no stipulations that the PBSP should be reviewed for efficacy prior to 6/2/2012, even if the rate of SIB increased substantially. • For individual #590, the treatment expectations for 250mg of Seroquel per day were indicated to be, "Ongoing treatment for maintenance." This expectation provided no guidance for what would be considered as a need to revise pharmacotherapy. Records reviewed as part of the current site visit also included situations in which individuals were expected to continue training well beyond the point of mastery. Under most circumstances, once an individual has demonstrated mastery of a task over several sessions, efforts can begin to fade the training and reinforcement procedures. Continuing training beyond mastery in many situations has little benefit for the individual and may create a situation in which participating in training is punishing. • For Individual #168, the treatment expectation was that the rate of appropriate refusal would be 80% of trials or greater for 8 consecutive months by 8/10/2012. This required the individual to successfully learn the behavior and continue participation in the program for eight months, even if the target decreased shortly after program implementation. It was noted during the September 2010 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. During the March 2011 site visit, it was noted that progress notes included behavior targets as well as psychotropic drug targets for 10 of 18 (56%) individuals sampled. At the time of the	

#	Provision	Assessment of Status	Compliance
		current site visit, the data graphs for 22 PBSPs were sampled. This sample revealed that 18 of 22 graphs (82%) included behaviors targeted for reduction and 20 of 22 graphs (91%) included behaviors targeted for increase. Based upon these data, it was noted that DSSLC continued to improve in relation to graphing appropriate treatment targets. In February of 2011, DSSLC implemented the first phase of a process to measure IOA for PBSP data. As the IOA procedure was implemented only a few weeks prior to the March 2011 site visit, it was not possible to effectively review the IOA data at that time. During the current site visit, DSSLC provided documentation of 617 IOA observations conducted between 2/10/2011 and 6/24/2011. The results of those observations are presented below.	

Location	Observer Agreement	Number of Observations
503	33%	3
504	51%	9
505	51%	52
506	62%	25
507	71%	88
508	89%	3
509	96%	6
510	100%	1
511	84%	61
512	80%	72
513	39%	4
514	76%	22
515	80%	30
520	74%	27
522	77%	24
523	74%	26
524	68%	2
525	84%	44
526	78%	34
527	83%	27
528	87%	38
ARC	83%	6
ETC	100%	1

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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<table>
<tr><td>Gym</td><td>96%</td><td>9</td></tr>
<tr><td>ICD</td><td>67%</td><td>3</td></tr>
<tr><td>Facility Average</td><td>75%</td><td>617</td></tr>
</table>

The initiation of IOA observations was a positive step by DSSLC. The initial results must be reviewed as preliminary, however. Although an average of 75% agreement over 617 observations was good, the total observations conducted over 134 days comprised an average of only 4.6 observations per day across the entire facility. Furthermore, the number of observations for several locations was very low. As a result, the Facility will need to increase the scope of IOA observations in order to reach substantial compliance with the SA.

It was evident during the site visit that effort had been made to improve the quality of behavior data. Despite these changes, however, the Facility continued to demonstrate weaknesses in developing and implementing a data collection and review system that would ensure effective and timely treatment.</td><td></td></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 selection and acquisition training.. 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.
<table>
<tr><th></th><th>3/2010</th><th>8/2011</th><th>Change</th></tr>
<tr><td>Standardized assessment or review of intellectual and cognitive ability.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Standardized assessment of adaptive ability.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Screening for psychopathology, emotional and behavioral issues.</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Assessment or review of biological, physical and medical status.	0%	0%	0%
Review of personal history.	0%	100%	100%
Psychological Assessments contained findings from an intellectual test administered within the previous five years.	0%	0%	0%
Psychological Assessments included a narrative summary of how the results from intellectual assessments more than five years prior would facilitate the understanding of the individual's strengths and needs.	0%	0%	0%
Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.	9%	0%	-9%
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.	0%	0%	0%

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

- For Individual #163, the most recent Intellectual testing was completed in 1989; no adaptive testing was reported.
- For Individual #533, the most recent intellectual and adaptive assessments were completed in 1989.
- For Individual #703, the most recent intellectual and adaptive testing was completed in 1987.

Reiss Screens contain information on psychopathology and emotional and behavioral issues and had been provided. However, the psychological assessments did not demonstrate integration of information from the Reiss Screen in making conclusions. The majority of reported Reiss Screen scores were accompanied only by a generic statement that described the scores as reflecting good mental health: There was no effort to interpret the ratings or integrate the scores with existing diagnoses of mental illness.

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

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
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.
<table>
<tr><th></th><th>Baseline</th><th>8/2011</th><th>Change</th></tr>
<tr><td>Functional assessments produced a specific statement or hypothesis of function.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Functional assessments consisted of procedures completed within a year prior to the initiation date of the PBSP.</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis.</td><td>0%</td><td>83%</td><td>83%</td></tr>
<tr><td>The process or tool utilizes both direct and indirect measures.</td><td>0%</td><td>83%</td><td>83%</td></tr>
<tr><td>Differentiation between learned and biologically based behaviors.</td><td>0%</td><td>17%</td><td>17%</td></tr>
<tr><td>Identification of setting events and motivating operations relevant to the undesired behavior.</td><td>0%</td><td>83%</td><td>83%</td></tr>
<tr><td>Identification of antecedents relevant to the undesired behavior.</td><td>0%</td><td>83%</td><td>83%</td></tr>
<tr><td>Identification of consequences relevant to the undesired behavior.</td><td>0%</td><td>83%</td><td>83%</td></tr>
<tr><td>Identification of functions relevant to the undesired behavior.</td><td>0%</td><td>83%</td><td>83%</td></tr>
<tr><td>Summary statement identifying the variable or variables maintaining the target behavior.</td><td>0%</td><td>67%</td><td>67%</td></tr>
<tr><td>Identification of functionally equivalent replacement behaviors relevant to the undesired behavior.</td><td>0%</td><td>17%</td><td>17%</td></tr>
<tr><td>Identification of preferences and reinforcers.</td><td>0%</td><td>17%</td><td>17%</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Based upon a review of the 12 most recent functional assessments, it was evident that considerable improvement had been achieved by DSSLC. Four specific areas stood out for the lack of substantial improvement. One of these areas, the differentiation between learned and biologically-based behaviors will be addressed later in Provision K5. The three remaining issues were as follows. • Production of a specific statement or hypothesis of function. All but one of the functional assessments reviewed included a variety of detailed statements regarding potential functions, motivating operations, setting events and antecedents related to the target behavior. Despite the identification of these factors, however, nowhere was there a concise statement that tied all factors together in a single hypothesis regarding the behavior. One of the core constructs of applied behavior analysis is that efforts to explain and change behavior must be empirical in nature. Therefore, one product of a functional assessment should be the proposal of a descriptive hypothesis to explain the undesired behavior. Built upon this descriptive hypothesis is a predictive hypothesis regarding how changes in the environment can change the behavior in question. For example, a descriptive hypothesis for a fictional person might be that, when placed in the absence of frequent verbal attention and then offered a prompt to perform a work task, the individual will refuse to complete the task because in the past such refusals have been followed by increased requests and attention. The predictive hypothesis would then be that, if placed in an environment with abundant verbal attention and then presented with a prompt to perform a work task, the individual will perform the task due to a) the removal of attention deprivation and b) having been provided with continued attention following completion of the task in the past. In the absence of specific descriptive and predictive hypotheses, the task of integrating the findings of a functional assessment into a coherent intervention can be challenging. By formulating the necessary hypotheses, however, the development of a successful intervention is more achievable in that the intervention methodology reflects the predictive hypothesis. • Identification of functionally equivalent replacement behaviors. Effective behavior change according to applied behavior analysis also includes the premise that in many circumstances a behavior that serves the same function as the undesired behavior is necessary to replace the undesired behavior. In the majority of the 12 functional assessments reviewed, there was not adequate attention given to the identification and selection of replacement behaviors. In some circumstances, the identified replacement behavior was a behavior that	

#	Provision	Assessment of Status	Compliance
		the individual possessed and used, but that was at times ineffective. In other cases, the identified replacement behaviors were socially desirable behaviors that were unrelated to the stated function of the undesired behavior. The inclusion in PBSPs of steps to strengthen these socially desirable behaviors might very well prove successful in increasing the display of these behaviors. Unfortunately, as these behaviors did not often share the function of the undesired target behavior, it was unlikely that an increase in the socially desirable behaviors would reduce the display of the undesired behavior. In order for DSSLC to achieve substantial compliance with the SA, it will be necessary to ensure that functional assessments identify, and PBSPs include, functionally equivalent replacement behaviors. For example: o For individual #163, the following information was included in the summary of the functional assessment. "[The Individual] is highly verbal and often seeks interaction from her peers and caregivers. She is quite capable of telling you that she doesn't want to do something and asking for things that she wants or needs. It is only when her verbal behavior is no longer effective at meeting her needs that she will begin to display maladaptive behavior." Nevertheless, the identified replacement behavior was, "Appropriate Task Refusal: When [the Individual] is presented with a task that she does not want to do, she will state "I do not want to do that." As the person was acknowledged to possess this skill and to use it on a regular basis, it was doubtful that efforts to strengthen this behavior would be necessary or produce meaningful changes in the individual's undesired behavior. • <u>Identification of preferences and reinforcers</u>. The majority of the 12 reviewed functional assessments included either no assessment of preferences and reinforcers or an informal assessment based upon subjective opinion. The correct identification of preferences and reinforcers is essential to the development of an effective behavior change program. To be effective, a PBSP must use a powerful and efficient form of reinforcement to strengthen behavior. Example: For individual #181, an informal preference assessment found that "he enjoys walks, soft drinks, milkshakes, soaking in a tub, sunbathing, green vegetables, music and sensory lights." None of these preferences were relevant to the undesired behavior or used in the PBSP. The issue of formal preference assessment was addressed with the statement "Informal assessment results seemed to provide an ample list of preferences. A formal assessment is not needed at this time."	

#	Provision	Assessment of Status	Compliance
		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 September 2010 site visit, DSSLC demonstrated considerable difficulty in incorporating the signs and symptoms of mental illness into the functional assessment process. Improvement was noted March 2011, but 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. Although considerable effort by DSSLC to resolve the weakness was noted during the current site visit, in the 12 most recent functional assessments there was minimal improvement.	

	3/2010	9/2011	Change
The assessment process included screening for psychopathology, emotional, and behavioral issues.	0%	17%	17%
The assessment process included differentiation between learned and biologically based behaviors.	0%	17%	17%
Identification of behavioral indices of psychopathology	0%	0%	0%
Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities	0%	17%	17%

The diagnosis and treatment of mental illness in people with concomitant intellectual or developmental disabilities requires a carefully coordinated approach. In many cases, symptoms of mental illness can be masked by limited expressive communication skills or other aspects of the developmental or intellectual disability. In addition, undesired behaviors may reflect the symptoms of mental illness as well as learned responses to environmental stimuli. It is therefore essential that the psychiatrist and behavior analyst work toward a common goal in a manner that allows their areas of expertise to complement each other.

The functional assessments and PBSPs most recently completed at DSSLC included

#	Provision	Assessment of Status	Compliance
		abundant information regarding psychiatric assessment and intervention. In the majority of cases, however, this information was presented as a window into a parallel treatment process rather than as an integration of behavior analysis and psychiatry into joint case formulation. For example, Individual #168 was diagnosed with Delusional Disorder based upon verbal statements regarding being married to celebrities or participating in a famous musical group. She was prescribed an antipsychotic drug to address this diagnosed mental illness. In addition, the individual was noted to display a behavior labeled as verbally disruptive behavior that comprised statements threatening harm to employees of the Facility. The narrative provided by the psychiatrist and observational notes from the psychologist described both forms of verbal statements. Neither the psychiatrist nor the psychologist, however, integrated the assessment or treatment process of both treatment targets, even though both targets involved verbal behavior and the available data revealed that the trends for both targets were closely correlated. A second example, as presented in the functional assessment, involved Individual #349 who was diagnosed by the psychiatrist with Schizoaffective Disorder – Depressed Type. A subjective review of the individual's presented symptoms, as provided by the psychiatrist, was included in the functional assessment to support the diagnosis and prescribed psychotropic medications. The assessment of behavior conducted by the behavior analyst included the statement that "Due to the fact that [the individual's] only target behavior is a psychiatric symptom, anecdotal assessments were not conducted." The functional assessment also included among the treatment targets a target labeled "Bad Mood". This target was comprised of multiple behaviors, including aggression toward personnel, slamming or kicking doors, refusing meals, shouting, and refusing to talk with staff. The functional assessment included no formal efforts to identify environmental components to the noted behaviors. Although it was positive that DSSLC had made efforts to include information from both psychiatry and behavior analysis in the functional assessment, the presentation of parallel processes is not sufficient for the development of effective interventions. It is essential that the two disciplines develop the means to integrate the assessment and treatment process. Observations and documentation reviewed as part of the current site visit revealed many areas of progress in relation to the assessment process. DSSLC will need to act diligently, however, to address the remaining areas of weakness in order to achieve substantial compliance with the SA.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year,	Based upon the information presented in Provision K5, minimal documentation in the record reflected assessment findings that were demonstrated to be current, accurate or complete.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.</td><td></td><td></td></tr>
<tr><td>K7</td><td>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.</td><td>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, 0% of the completed evaluations included current intellectual testing results or current adaptive skill assessments.

<table><tr><th></th><th>Baseline</th><th>9/2011</th><th>Change</th></tr><tr><td>Individual records demonstrate that these psychological assessments are conducted as often as needed, and at least annually, for each individual.</td><td>0%</td><td>0%</td><td>0%</td></tr><tr><td>For newly admitted individuals, psychological assessments are conducted within one month.</td><td>0%</td><td>0%</td><td>0%</td></tr></table></td><td>Noncompliance</td></tr>
<tr><td>K8</td><td>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.</td><td>During the previous site visit, it was noted that DSSLC completed and implemented Counseling Policies and Procedures on 12/01/2010. These policies provided the necessary structure for 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.

At the time of the current site visit, DSSLC reported that 22 individuals were receiving counseling through the Behavior Services department at DSSLC. In order to assess the status of counseling interventions, a sample of six counseling plans (27%) was selected.

<table><tr><th></th><th>Baseline</th><th>9/2011</th><th>Change</th></tr><tr><td>Needed services (other than PBSPs, e.g. counseling) identified in the psychological assessment are implemented within 6 weeks of the assessment.</td><td>0%</td><td>100%</td><td>100%</td></tr><tr><td>Services are goal directed with measurable objectives</td><td>0%</td><td>0%</td><td>0%</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

and treatment expectations.				
Services reflect evidence-based practices.	0%	0%	0%	
Services include documentation and review of progress.	0%	0%	0%	
Individuals who provide therapeutic interventions are qualified to do so through specialized training, certification, or supervised practice. Individuals who assist as staff participants or who supervise homework or milieu activities receive training and monitoring from qualified therapists.	0%	100%	100%	

Based upon the sample of counseling plans, as well as interviews with three Behavior Services personnel who provide counseling, it was evident that considerable effort was invested in the provision of counseling services. All personnel who provided counseling were Licensed Professional Counselors (LPC). Procedures for referring, assessing and providing treatment were diligently adhered to. Therapy notes were in place for all individuals involved in counseling.

Despite the effort by the personnel involved, however, the counseling services offered at DSSLC did not meet the criteria established in the SA. None of the plans reviewed included an evidence-based approach to treatment. Treatment goals and initial assessments lacked objective and measurable treatment expectations. Counseling notes lacked specific data and were often subjective opinions of poorly defined behaviors.

It was encouraging that the Facility was able to provide personnel who were enthusiastic about and invested in the provision of counseling services. In order to satisfy the SA, however, DSSLC will need to take steps to ensure that counseling services reflect an evidence-based approach to treatment.

K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been	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 September 2010 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. • None of 29 records reviewed (0%) reflected the use of more rigorous or empirical procedures necessary to clarify potential functions and address	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>limitations inherent to indirect functional assessments.

During late 2010 and early 2011, 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. This was followed by a revision of the PBSP format during the Summer of 2011. As the PBSP revision had been recently implemented, there were few PBSPs to review that reflected the new process; a total of 12 were provided by the Facility. Based upon observations and a review of those 12 PBSPs, the following trends were identified.

<table>
<tr><th>PBSP Element</th><th>Baseline</th><th>9/2011</th><th>Change</th></tr>
<tr><td>Rationale for selection of the proposed intervention.</td><td>50%</td><td>83%</td><td>33%</td></tr>
<tr><td>History of prior intervention strategies and outcomes.</td><td>50%</td><td>100%</td><td>50%</td></tr>
<tr><td>Consideration of medical, psychiatric and healthcare issues.</td><td>40%</td><td>40%</td><td>0%</td></tr>
<tr><td>Operational definitions of target behaviors.</td><td>70%</td><td>51%</td><td>-19%</td></tr>
<tr><td>Operational definitions of replacement behaviors.</td><td>70%</td><td>51%</td><td>-19%</td></tr>
<tr><td>Description of potential function(s) of behavior.</td><td>30%</td><td>67%</td><td>37%</td></tr>
<tr><td>Use of positive reinforcement sufficient for strengthening desired behavior</td><td>10%</td><td>17%</td><td>7%</td></tr>
<tr><td>Strategies addressing setting event and motivating operation issues.</td><td>60%</td><td>83%</td><td>23%</td></tr>
<tr><td>Strategies addressing antecedent issues.</td><td>60%</td><td>83%</td><td>23%</td></tr>
<tr><td>Strategies that include the teaching of desired replacement behaviors.</td><td>10%</td><td>17%</td><td>7%</td></tr>
<tr><td>Strategies to weaken undesired behavior.</td><td>30%</td><td>30%</td><td>0%</td></tr>
<tr><td>Description of data collection procedures.</td><td>20%</td><td>100%</td><td>80%</td></tr>
<tr><td>Baseline or comparison data.</td><td>0%</td><td>67%</td><td>67%</td></tr>
<tr><td>Treatment expectations and timeframes written in objective, observable, and measureable terms.</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>
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#	Provision	Assessment of Status	Compliance

Clear, simple, precise interventions for responding to the behavior when it occurs.	30%	0%	-30%
Plan, or considerations, to reduce intensity of intervention, if applicable.	0%	67%	67%
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 integration of psychiatric and behavior services, operational definitions, the formal teaching of replacement behaviors, the identification and use of powerful reinforcement strategies, the establishment of objective and meaningful treatment expectations, and easily read instructions for program implementation. Examples of weaknesses are presented below. Issues regarding replacement behaviors, psychiatric treatment, and treatment expectations have been addressed elsewhere in Section K.

Operational definitions. In many of the reviewed PBSPs, the definitions of behaviors targeted for either increase or reduction were overly broad. For example, in regard to Individual #187, physical aggression was defined as "hitting, poking, pushing, or pinching others." Without further definition, these terms encompassed a wide variety of potential behavior displays, which might not necessarily reflect the intent of the psychologist who had developed the PBSP. For the same individual, aggression toward property was defined as when [the individual] damages or breaks an inanimate object. According to this definition, if the individual tripped and knocked over a lamp, breaking the bulb, the incident would have to be recorded as a display of the target behavior. Without specificity, DCPs are left to formulate a best guess as to what constitutes a display of the target behavior. This in turn prevents valid and reliable measurement of improvement in an individual's behavior.

Use of positive reinforcement. As previously discussed, functional assessments seldom included a formal assessment of preferences or reinforcers. As a result, regardless of how the PBSP was written, it was not possible for the persons developing or implementing the PBSP to be confident that the consequence for the desired behavior was in fact likely to strengthen that behavior.

Easily read instructions in PBSPs. Two measures of readability are the Flesch Reading Ease score and the Flesch-Kincaid Reading Grade Equivalent. During previous site visits, reviews of the section of the PBSPs for DCPs to use reflected substantial variability on both of these measures across psychologists. During the current site visit, the variability

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>was substantially reduced. At the same, however, the scores achieved by the PBSPs on the two measures listed above increased. For many PBSPs, the Reading Ease score remained in the mid-50s, indicating a required reading ability of advanced high school or early college, while the Grade Level scores fell within late 9th to early 10th grade level.

One problem when using formulas to calculate readability is that there is variation across various versions of the same formula. The formulas included in Microsoft Word 2010, used by the Monitoring Team, can produce scores that reflect greater difficulty than other versions of the formulas. To avoid confusion in this area, it is recommended that DADS adopt criteria for readability that clearly specifies the formulas and procedures to be used.

An additional measure of readability involves input solicited from the DCPs. This measure also presents confounds in that the opinions of the DCPs are subjective and can be influenced by extraneous factors. For the 12 PBSPs reviewed during the current site visit, this was not an option, nor was the observing of staff carrying out the PBSPs, as many of the PBSPs had not yet been implemented.

Based upon the review of the 12 most recent PBSPs, it did appear that progress had been achieved in many areas. In several areas, however, additional progress was necessary before the PBSPs were in substantial compliance with the SA.</td><td></td></tr>
<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.

Requirements for graphs and the percentage of graphs in compliance from a sample of 20 individuals are presented below.

<table>
<tr><td>Graph Element</td><td>Baseline</td><td>9/2011</td><td>Change</td></tr>
<tr><td>Data Graphed at least monthly</td><td>90%</td><td>100%</td><td>10%</td></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>100%</td><td>70%</td><td>-30%</td></tr>
<tr><td>Horizontal axis and label</td><td>100%</td><td>100%</td><td>0%</td></tr>
<tr><td>Vertical axis and label</td><td>0%</td><td>40%</td><td>40%</td></tr>
<tr><td>Condition change lines</td><td>0%</td><td>20%</td><td>20%</td></tr>
<tr><td>Condition labels</td><td>0%</td><td>20%</td><td>20%</td></tr>
<tr><td>Data points and path</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>IOA and data integrity</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Demarcation of changes in medication, health status or other events | 0% | 30% | 30% During the September 2010 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 behavior 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 March 2011 site visit, 53% of data graphs reviewed that were created after January 1 2011 included indicators for changes where appropriate. At the time of the current site visit, a review of the data graphs for 20 PBSPs revealed the success in this area had fallen to 20% of reviewed PBSPs. 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 seldom 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 or controlled treatment changes based upon treatment expectations and time frames. 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, which continued into the time of the current site visit. Issues relating to the collection of IOA data are presented in Provision K4. It was noted, however, that none of the 20 graphs reviewed during the current site visit included IOA information.	
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	As noted in Provision K9, limitations existed during the current site visit in relation to assessing the ease with which DSPs could read and use the latest PBSPs. Direct information was unavailable, as many of the plans had not been implemented. In addition, more objective measures did not reflect stability across measures; at the time of the site visit, the Behavior Services department had begun but not yet fully implemented the single measure of readability. It is recommended that DADS adopt criteria for readability	Noncompliance

#	Provision	Assessment of Status	Compliance
	implemented by direct care staff.	that clearly specifies the formulas and procedures to be used.	
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 seven staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 74 individuals residing at the Facility and fell far short of the required ratio of one BCBA for every 30 individuals. The Behavior Services department did include a sufficient number of positions to achieve a 1:30 ratio. Should a BCBA credentialed employee fill each available position, DSSLC would achieve approximately a 1:26 ratio. The Facility also employs sufficient Psych Assistants to provide one Psych Assistant for every two full-time psychologists. 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. The Facility should continue to expand IOA data collection to ensure that an adequate number of observations are conducted across all relevant settings. (Provision K.4)
2. Data collection in relation to the symptoms of mental illness should be enhanced so that more formal and objective measures are used in the place of non-standardized Likert-type rating scales. (Provision K.4)
3. The Facility should aggressively improve the provision of intellectual and adaptive assessment services so that all persons have an intellectual assessment completed in the last five years and an adaptive assessment completed within the past 12 months. (Provision K.7)
4. Functional assessments should be revised to ensure that specific descriptive and predictive hypotheses are presented, to ensure that replacement behaviors are functionally equivalent to the undesired behaviors, and that formal preference assessments are completed. (Provision K.5)
5. The process of identifying the targets for psychotropic intervention must be integrated into the functional assessment process, rather than running in parallel to the assessment of behavior function. (Provision K.5)
6. The provision of counseling service should be revised so that all efforts involving assessment and treatment conform to the expectations of evidence-based practice. (Provision K.8)

7. Behavior interventions should be enhanced to ensure that targets are appropriately defined, treatment expectations with success and failure criteria are included, and effective use of reinforcement is ensured. (Provisions K.4 and K.9)
8. Steps should be taken to ensure that treatment data graphs include all components expected by current practice in applied behavior analysis. (Provision K.4)

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. DSSLC Plan of Improvement 9/7/11 2. DSSLC Section L Presentation Book (undated) 3. DSSLC Policy CMGMT-15 Quality Enhancement Process, dated 1/5/10 4. Medical Care Policy draft, dated 8/17/10 5. DSSLC Revised Local Policy - "Clinical Death Review Committee", 07A 6. DADS Policy: Emergency Response, Policy Number: 044.2, Effective: 9/7/2011, Replaces: 044.1 7. DSSLC Safety and Security Services, Operating Instructions, no date 8. DSSLC Policy: Committees and Councils–10 Drill Committee, Policies and Procedures, Date: 9/19/2011 9. Annual PSP, dated 2011, Annual Physician's Summary (2011), Annual PT/OT Assessment (2011) for Individuals #383, #214, and #252 10. PSP, past six months labs, Annual Physician Review, diets for past one year, current medication list and Annual Physician's Review for Individuals #787, #556, #517, and #384 11. Past six months Medication Administration Records, most recent PSP, most recent Annual Physician's Review, current medication list for Individuals #35, #275, #335, 395, #367, #242, and #753 12. Blood glucose spreadsheets for July and August 2011 13. List of Individuals who have diagnosis of spasticity 14. Clinical record for Individual #384 15. Community Living Discharge Plan, dated 9/20/11, for Individual #384 16. Last ten Medical Provider QA Audits – Follow-up Results and Action Plans for September, 2011 17. Blank copy of the Medical Provider QA Audit form 18. Last ten Internal Medical Audits 19. Department of Health and Human Services Center for Medicare and Medicaid Services, Provider Identification Number: 45G004, Form CMS-2567, Printed: 6/21/2011 20. DSSLC Fire Drill Meeting Minutes, 3/1/2011, 6/17/2011, and 9/2/2011 21. DSSLC Incident Management Review Team Meeting Notes/Logs, 8/17/2011, 8/26/2011, 8/29/2011, 8/30/2011, and 8/31/2011 22. DSSLC Different Scenarios Used During Cardiopulmonary Resuscitation (CPR) Drills 23. DSSLC Medical Emergency Drill Compliance Trending Report, 1/11/2011 through 8/31/2011 24. DSSLC List of Staff Responsible for Conducting, Reporting, and Tracking Mock Medical Emergency Drills 25. DSSLC Facility List Identifying the Location of all Emergency Equipment 26. DSSLC Mock Medical Emergency Drill Monthly Schedules for past six months 27. DSSLC Completed Mock Medical Emergency Drill Sheets for past six months 28. DSSLC Completed Emergency Equipment Checklists for the 7/2011 and 8/2011 29. DSSLC Course Due/Delinquent Training List for Course: CPR0100 – CPR: Basic, Printed: 8/22/2011 30. DSSLC Course Due/Delinquent Training List for Course: CPR0250 – Basic Life Support (BLS) for Health Care Providers, Printed: 8/22/2011 31. DSSLC Clinical Death Review Policies and Procedure Manual, Committees and Councils – 07A, Date:

	May 15, 2006 32. DSSLC Administrative Death Review Committee, Policies and Procedure Manual, Committees and Councils – 07B, Date: May 1, 2006 33. DSSLC Death Reports, 8/27/2010 through 9/5/2011 34. DSSLC Death Review Compliance Report, 4/2011 through 9/2011 35. DSSLC Administrative Death Review – Recommendation Tracking Log, 4/2011 through 9/2011 36. DSSLC Clinical Death Review – Recommendation Tracking Log, 4/2011 through 9/2011 37. DSSLC Death/Discharge Summaries for Individuals: #723, #569, #8, #387, #342, #782, #338, #267, #245, and #504 38. DSSLC Unusual Incident Investigation Reports for Deaths of Individuals: #723, #569, #8, #387, #342, #782, #338, #267, #245, and #504 39. Review of Administrative and Clinical Death Review Committee Minutes for Individuals: #723, #569, #8, #387, #342, #782, #338, #267, #245, and #504 **People Interviewed:** 1. Diane Porter, RN, BSN 2. Dr. Kubala, MD, Medical Director 3. Dr. Lee, MD, QA Physician 4. Interviewed Emergency Response Committee Members, 9/19/2011 5. Deb Salsman, Director of Incident and Risk Management 6. Chuck Brookins, Security Officer 7. Jeron Dotson, Incident Management Coordinator 8. Allana Garrison, RN, Quality Assurance Nurse Supervisor 9. David Anderson, Assistant Security Officer 10. Delia Schilder, RN, Chief Nurse Executive (CNE) 11. Sherri Courtney, RN, Nursing Operations Officer (NOO) 12. Interviewed Nursing Staff regarding Death Reviews: • Delia Schilder, RN, Chief Nurse Executive (CNE) • Sherri Courtney, RN, Nursing Operations Officer (NOO) • Laura Stoffels, RN, Nurse Investigator **Meetings Attended/Observations:** 1. Discharge planning meeting for Individual #384 2. Observations of Individual at their living areas: Cedar Falls A; Bowie 509, Timberhill 3. Direct observation of Individuals: #61
	Facility Self-Assessment: In the POI, the Facility reported it was not in compliance with any of the provisions of Section L. The Monitoring Team concurs. The Facility did not appear to have any formal process from which it determined compliance ratings for this section of the SA. The POI reported a number of actions that had been taken to progress toward compliance but did not provide information on a sequential plan of actions to lead from current status to compliance, including steps completed and data on expected outcomes.

	The Facility also provided Action Plans for Provisions L.1, L.2, and L.3. These identified a number of actions that the Facility is in process of implementing or plans to implement. Although they may be important actions, these actions do not, however, provide a sequential plan to lead from current status to compliance. Provision L1: The Facility determined that it was noncompliant with Provision L.1. The Facility reports completing many activities, as outlined on the POI. The Facility recognized that the management of chronic care issues remains an issue for the Facility, and is developing a strategy to ensure that the management of chronic care conditions is enhanced. Provision L2: The Facility concluded that it was noncompliant with Provision L.2. The Facility reports accomplishing many activities, as outlined on the POI; however, as reported by the Medical Director they are awaiting further direction from DADS Central Office with regards to developing a mechanism to assess physician competencies. Provision L3: The Facility determined that they were not in compliance with Provision L.3, of the Settlement Agreement, and recognized that they have yet to develop and implement a mechanism to identify clinical indicators for medical quality assurance, nor have they developed a process to collect, track, and conduct data analysis for QA issues. The Facility has dedicated a full time physician to conduct quality assurance reviews; however, their process has yet to be fully developed, and they are awaiting further direction from DADS Central Office. Provision L4: The Facility reported that they remain noncompliant with Provision L.4, of the Settlement Agreement. The Facility is waiting on further direction from DADS Central Office to provide Clinical Pathways, to help ensure that acceptable practice standards are achieved.
	Summary of Monitor's Assessment: Provision L1: The Monitoring Team concurs with the Facility's self-assessment of not being in compliance with Provision L.1. The Facility must better address the management of acute and chronic care conditions and seek understanding of the underlying etiology of medical conditions. Medical Services must become fully integrated in the team process. The Facility has made significant improvements with physician documentation practice and on follow-up on acute conditions, and has implemented a good internal review process. The Facility's plan of improvement does not enable the Monitoring Team an understanding of forward action steps required to become compliant with Provision L1. Provision L2: The Monitoring Team is in alignment with the Facility's self-assessment of not being compliant with Provision L.2. The Facility has yet to implement a mechanism to assess and ensure physician's clinical competency. The Facility has developed a process for internal reviews and has participated in the DADS Medical Provider Quality Assurance Audits. The current Medical Provider Quality Assurance Audits assess the clinicians' ability to adhere to operational needs, such as appropriate documentation, and timely follow-up; however, it does not enable a meaningful mechanism to assess clinical competency of the practicing clinician.

	Provision L3: The Monitoring Team agrees with the Facility's self-assessment of not being in compliance with Provision L.3. At the time of this review, the Facility did not have a process in place to identify clinical indicators and did not conduct data analysis for medical QA purposes. The Monitoring Team identified substantial improvements in the area of mortality review process. Provision L4: The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this Provision. During its review, the Monitoring Team identified many issues, especially in the area of chronic care management, that require significant enhancements. The pending clinical pathways should help the Facility achieve compliance. The current POI did not provide the Monitoring Team with an appreciation of its overall plan of improvement, as it contained mostly a list of activities completed and not a forward action plan.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	<u>General Medical Care and Physician Participation in Team Process</u> Since the last review, the Monitoring Team appreciates that there had been many improvements in the area of medical care at the Facility. Clinicians are better documenting clinical issues and plans. Triaging acute medical problems had improved, and many Annual Physician's Summaries are more complete and delineated a comprehensive treatment plans, leading to a good understanding of the Individuals medical condition. There had been some improvement with participation by clinician staff at Team Meetings To assess the delivery of the medical care at the Facility, the Monitoring Team focused this review on the integration of medical care into the Personal Support Team process, care and support of several chronic medical conditions, including spasticity, Phenylketonuria (PKU), diabetes mellitus (DM), pneumonia, and community living discharge planning. Spasticity: The Monitoring Team requested a real-time list of all individuals who had the diagnosis of Spasticity. The list consisted of 14 Individual names. By observation, the Facility served numerous individuals who had spasticity, but who were not appropriately accounted for on the list. The Monitoring Team assessed the Facility's ability to support individuals with chronic spastic conditions, such as Cerebral Palsy (CP). The Monitoring Team recognizes that assertive management of such conditions is necessary, should occur lifelong, and requires a multidimensional process that focuses on maintenance, and on prevention of associated conditions such as contractures, fractures, degenerative spine disease,	Noncompliance

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		osteoarthritis, pain, poor hygiene, skin breakdown, urinary tract infections, cardiopulmonary compromise, and dislocations. The following three examples delineate the Facility's lack of comprehensive management of spastic conditions: • Individual #383: It was noted on the 2011 Annual Physician's Summary that the Individual had spastic quadriplegia, scoliosis, and spinal fusion with Harrington Rod placement in 1993. The 2011 Occupational Therapy/Physical Therapy (OT/PT) assessment noted the same diagnosis; however, it also reported involuntary athetoid movements. Both the active problem list and the OT/PT assessment failed to include the diagnosis of CP, which the individual was known to have per admission records. The OT/PT assessment did not include a comprehensive assessment for the individual's OT/PT needs. PT assessment should be conducted at least annually and evaluate range of motion, and assess degree of contractures and spasticity, among other things. The OT assessment should evaluate sensory, cognitive and motor abilities. The treating physician must be provided meaningful assessments in order to ensure that appropriate treatment is being offered. The Physicians Annual Summary and the OT/PT assessment did not offer specific recommendations for the ongoing management the individual's spasticity and CP. The last x-ray of the thoracolumbar spine was in 2007. There were no referrals to an orthopedic or rehabilitation specialist noted in the clinical, record and the physician did not follow-up on this condition. The individual was provided Tizanidine for spasticity, which is a medication that can cause drug induced hepatitis. The Individual was noted to have elevated hepatic enzymes and Tizanidine was not suspected as a potential cause. Also, there were no protocols noted to assess for orthostatic hypotension, which is another serious side effect of Tizanidine, and should be monitored regularly. Furthermore, there were no assessments to evaluate for the efficacy of this medication. Most important was the observation that the Personal Support Plan (PSP), dated April 5, 2011, did not adequately address the general issues and support needs for the individual's CP, and spastic quadriplegia. Overall, the Monitoring Team determined that maintenance of this chronic condition was suboptimal. • Individual #252: The individual was noted on the 2011 Annual Physician's Summary to have a diagnosis of severe spastic quadriplegia, scoliosis and dislocated right hip. There were no indications that these conditions had been referred for specific diagnostics, such periodic as x-rays, or other imaging studies to assess for worsening, nor were there indications that the individual was referred to orthopedic or rehabilitation specialists. The physician did not routinely evaluate him for these serious chronic conditions. The Annual PT/OT Assessment dated 2011, did not adequately assess these conditions and lacked specific PT/OT recommendations for the management of chronic spasticity, CP and hip dislocation. The Annual PSP dated 2011 did not adequately address the	

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		general issues and support needs for the individual's CP, spastic quadriplegia and chronic hip dislocation. The Individual was on Baclofen, a medication used to treat spasticity; however, there were no assessments to evaluate efficacy. The Monitoring Team determined that maintenance of the chronic conditions was suboptimal. • Individual #214: The OT/PT Assessment dated 2011 noted a diagnosis of Spastic quadriplegia, postural kyphosis, bilateral elbow contractures, bilateral coxa valga, history of tendon releases, bilateral Grice procedures, and a triple arthrodesis bilaterally. The Annual Physician's Summary, dated 2011, noted spastic quadriplegia, osteoarthritis and history of bilateral ankle arthrodesis due to extreme eversion of the ankles. The Physician's Plan and recommendations did not address any orthopedic condition or condition related to spasticity, other then indicating that the individuals osteoarthritis "is asymptomatic" and to "continue current medication for osteoarthritis". There were no diagnostics, such as imaging studies, or referrals to orthopedics or rehabilitation specialists. The OT/PT assessment dated 2011 did provide appropriate assessment of arm and leg movements, and they recommended a program to help maintain functional range of motion. There were no data, however, used to determine if the individual's condition was worsening, improving or unchanged. The PSP did address the PT/OT assessment. Importantly, the PSP commented that there were no functional changes noted and discussed the individual's endurance by comparing data to the previous year. Given the significant neuromuscular and orthopedic conditions the Individual has, and lack of more thorough assessment and routine follow-up by the physician for these conditions, the Monitoring Team determined that maintenance of the chronic conditions was below the level of standard of care. The Monitoring Team noted improvements made by PT/OT and enhanced Team process. PKU: To assess the delivery of medical services at the Facility, the Monitoring Team reviewed chronic medical management of four individuals who had a diagnosis of phenylketonuria (PKU). PKU is a serious disorder of metabolism that should be treated throughout adulthood, unless there is well defined and substantiated rationale for not providing treatment. Untreated, elevated PKU levels can cause memory problems, attention and planning difficulties, organizational problems, decrease mental processing speed, depression, mood disorders, and seizure exacerbation. • Individual #787: A monthly PKU level was obtained by the physician; however, the levels were consistently elevated. This was attributed in the PSP as resulting from the physician easing up on the individual's PKU diet, because of weight loss. There were no comments noted in the clinical record regarding alternative dietary approach to maintain lower PKU levels. Importantly, based on review of	

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		the clinical record the medication Kuvan, which is used to help lower PKU level levels, was not considered by the physician or team. The Individual's diet did not comment on the need to avoid aspartame, which is ubiquitous in foods, and adversely affects people with PKU. The individual was prescribed olanzapine, which should only be used in extreme cases, and when clinically justified when administering the medication to individuals with PKU. There was no discussion in the clinical record regarding the administration of olanzapine to this individual. Olanzapine can exacerbate symptoms of PKU, including seizures. • Individual #517: This individual was reported in the Medical Summary to have mental retardation secondary to PKU. It was reported that the individual had two sisters who had PKU, one of whom had died. The individual had not had a PKU level drawn in at least six months. The individual was known to have significant psychiatric symptoms, including severe aggression, self-injurious behavior, and mood disorder, and was prescribed Abilify, which is an antipsychotic that can worsen the symptoms of PKU. There was no rationale provided regarding the treatment with Abilify and known PKU. The PSP did not address the PKU diagnosis. • Individual #556: The Annual Physician's Review dated 2011 listed PKU on the problem list, and stated that "PKU was confirmed with lab on 3/12/08, but no treatment was indicated". There were no PKU levels obtained subsequent to 3/12/08. The physician's stated plan and recommendation for PKU indicated that "even though patient's phenylalanine is high (PKU), patient does not have significant behavior problem or any seizure activity so no need for PKU diet." The individual was noted to have a seizure diagnosis and is treated with medication for seizure disorder. The PSP provided for review, dated 10/10, was incomplete (only two pages provided for review, and the medical component was missing). • Individual #384: This individual was diagnosed with PKU in 2007. The team attempted a PKU diet; however, the physician documented in the 2011 Annual Physician's Summary that the PKU diet was discontinued because the diet led to abnormal behaviors. The Annual 2011 PSP did not comment on the individual's diagnosis of PKU, nor was there rationale outlined for discontinuing the PKU diet. The treating physician reported to the Monitoring Team that she contacted a geneticist regarding discontinuation of the Diet "some while ago," who reportedly concurred with discontinuing the PKU diet, given the worsening of the behavior. There was no documentation found in the clinical record regarding contact with the geneticist. Importantly, a gradual re-initiation of a PKU diet was not attempted. Importantly, medication used to help treat PKU, was not considered by the team.	

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		Following review of the four individuals with the diagnosis of PKU, the Monitoring Team raised concerns over the general management of this chronic medical condition, and determined that the overall management was suboptimal. The Monitoring Team recognized that all individuals may not tolerate a PKU diet; however, the team must consider strategies to assist individuals in achieving PKU diet success, such as gradual initiation of a PKU diet with substitutions, also helping staff better understand ways of supporting individuals on PKU diets, and considering the use of new medications, such as Kuban, as part of an overall treatment approach. Regular laboratory monitoring for PKU should also be considered. Diabetes Mellitus: The Monitoring Team selected four individuals to evaluate the management of diabetes mellitus from a list of individuals that the Facility provided the Monitoring Team: • Individual #517: This individual is known to have diabetes mellitus (DM), and is on oral medication, two different types of scheduled insulin, and a sliding scale insulin administration. Importantly, the individual was noted to have other associated conditions of metabolic syndrome, including hypertension and hyperlipidemia. The Annual PSP, dated 6/15/11, noted the diagnosis of DM and determined that the individual's fluctuating glucose levels is a primary obstacle for her moving to a more integrated environment. The PSP did not, however, delineate supports and services that are necessary to help the individual achieve more normal blood sugar levels. There was no action plan addressing DM. There was no team discussion about dietary approaches, the need for regular exercise, and perhaps the use of alternative treatments, such as an insulin pump, if appropriate. The Monitoring Team noted significant fluctuation in the individual's blood glucose levels, ranging from the 400's to hypoglycemic levels in the 50's. Review of the Annual Physician Summary, dated 6/9/11, indicated that the individual was not seen during any "clinic visits" to assess the individual's DM. During the previous six months, the individual was seen on three occasions by an endocrinologist. Following its review of this Individual for DM, the Monitoring Team determined that the Facility did not appropriately provide services and supports to help achieve stabilization of the individual's glucose levels. The Team should review more assertive team management, including enhanced education of staff, the individual and perhaps family members on DM, enhanced dietary management, and mechanisms to improve physical exercise. • Individual #35: This individual is diagnosed with uncontrolled DM. The Annual Physicians Summary, dated 5/4/11, indicated that the individual was seen on only two occasions for DM management. On 3/15/11, the individual's insulin was adjusted and on 3/23/11, the individual was seen for a routine exam and follow-up on blood sugars. The Individual was seen frequently by a consultant	

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		endocrinologist because of uncontrolled blood sugars. The Plan and Recommendation for DM included medication management but did not address other treatment potentials, including education (Staff, Individual and Family), dietary enhancements, and exercise. There was no assertive plan to mitigate the need for regular sliding scale insulin. The PSP, dated 5/10/11, did not assertively address the supports and services necessary for the management of DM. In fact, there were no objectives for the comprehensive management of DM noted in the PSP. • Individual #276: The individual was diagnosed with DM type II. The PSP, dated 2/7/11, noted that the individual had a diagnosis of DM; however, the risk assessment reported the individual to only be at a medium risk for DM. The PSP did not comment on supports or services necessary for the management of DM. Per review of the Annual Physician's Summary, dated 1/14/11, there was no indication that the individual was seen in the past year, at a clinic visit, to assess DM. The Annual Physician's Summary's Plan and Recommendations outlined the need for enhanced medication management, but did not address other treatment options, including nutritional, exercise, alternative insulin delivery systems, and education of staff, individual and family. In addition to scheduled insulin, the individual was also prescribed sliding scale insulin. • Individual #335 has a diagnosis of insulin dependent DM. The most recent PSP, dated 2/24/11, noted that the individual was high risk for DM; however, the PSP did not delineate supports and services for this chronic medical problem. The Annual Physician's Summary, dated 2/25/11, documented a plan to address medication management for hyperglycemia and to ensure that regular podiatry visits, daily aspirin, and yearly microalbumin urine test are obtained. The individual was noted to have had poorly controlled blood glucose levels and associated complications of DM, including diabetic retinopathy, uncontrolled hypertension, peripheral vascular disease, and hypercholesterolemia. In addition to scheduled insulin, the individual required sliding scale insulin daily. There was no comprehensive plan to address the overall management of DM. • The PSP and addendum to the PSP for the following Individuals, who are prescribed sliding scale insulin, did not delineate necessary supports and services for DM: #395, #367, #242, and #753. As noted in Provision M.1, there were examples in which coordination of services resulted in better diabetic control. Clearly, there were improvements in supports and services for individuals with diabetes, but further improvement is needed. In addition to the four case examples, the Monitoring Team reviewed the Facility's ability to ensure that blood glucometers on the living units were calibrated as necessary. On the	

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		two living areas visited (Timberhill A & C; Bowie 509), the Monitoring Noted that the blood glucose monitors were not calibrated per the Facility's policy, or per the manufacturers recommendations. Importantly, nursing staff at the living area's reported that they were unaware of a policy for calibrating glucose monitors. Not calibrating glucometers may lead to medical mishaps that can be serious and potentially cause death, secondary to iatrogenic hypoglycemia. The Monitoring Team met with Diane Porter, RN, BSN, who had served as the Facility's Diabetic Educator since February, 2011. Ms. Porter reported significant efforts to enhance diabetic management at the Facility, such as participating at Infirmary Rounds, providing physicians with monthly summaries of glucometer results, attending all endocrinology consults, and providing diabetic education to staff. She also developed a comprehensive procedure for the calibration of glucometers. It was also noted that physicians are addressing episodes of hypoglycemia and hyperglycemia more assertively and documenting their findings and clinical rationale. The Monitoring Team recognized that the efforts of Ms. Porter had only recently been implemented, which may account for the discrepancy between the Facility's reported new practice standards for the management of DM, versus the observations by the Monitoring Team. It is essential, however, that the Facility quickly implement a comprehensive management program that ensures standard of care practice is achieved for all Individuals with DM. Issues such as the pervasive use of sliding scale insulin must be mitigated, when possible; consideration of alternative delivery systems for insulin; incorporating behavioral approaches; enhancing dietary and exercise regimens; and individual, and general educational venues must be either developed or enhanced. Importantly, the PSP must accurately reflect the supports and services necessary to manage DM. Of significance is the immediate need to better educate nursing staff on the calibration of glucometers - Failure to ensure appropriate calibration can lead to serious adverse outcomes, including death. The frequency and timing of obtaining blood glucose readings should be reviewed and ensure that appropriate data is available that enables rational decisions for changing insulin doses, and minimize the need to use sliding scale insulin. Pneumonia: The Facility experienced a significant number of cases of pneumonia during the past quarter. Seventy-eight cases were diagnosed in approximately15% of the Facility's population. Observations of the living area demonstrated serious problems in the area of positioning, especially for individuals who were fed per enteric tubes. This issue was raised by several members of the Monitoring Team, and is well delineated in Section O of this report. The issue was immediately brought to the attention of the Facility leadership, and discussed with the Medical Director. The Monitoring Team was informed	

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		that the Facility monitors cases and trends of pneumonia by means of the PNMC meetings. Review of the PNMC minutes for the past six months indicated that the Facility did not address pneumonia through a systems approach. The minutes did not reflect tracking of pneumonia cases and there was no organized approach to the management of aspiration pneumonia at the Facility. The Monitoring Team determined that the Facility did not provide comprehensive management for individuals who were susceptible to aspiration pneumonia. Pneumonia is the leading cause of death for individuals with severe and profound intellectual disabilities. The Facility must ensure that there are systems in place to track pneumonia, determine underlying causes of recurrent pneumonia, and ensure appropriate supports and services are in place through a meaningful interdisciplinary team approach. Community Living Discharge Planning Meeting: Following its observation of the Community Living Discharge plan meeting, and review of the clinical record for Individual #384, the Monitoring Team determined that the Facility was deficient in assessing and reporting of significant medical conditions that required further follow-up and treatment, prior to transfer to the community. The accepting agency was not made aware of many chronic medical conditions. The individual had a diagnosis of PKU, for which he was not treated. The individual had a positive hepatitis B antigen which was not reported to the accepting agency. A recent weight loss of 12 pounds was not appropriately evaluated, nor reported to the accepting agency. No specific information was provided about the individual's significant gastroenterology conditions, including diverticulosis, and past history of H pylori that was not further evaluated to ensure treatment was efficacious. There was no current diagnosis of CP; however, old records indicated a diagnosis of CP. The accepting agency was not aware of the diagnosis of CP and what supports and services were necessary when caring for this individual. The individual had a history of two significant surgeries, a thoracotomy and abdominal hernia repair, both of which were not reported to the accepting agency. The PST's understanding of a major fall that the individual sustained in 2007, with subsequent ambulation problems that continue to worsen, was less than optimal. Importantly, the individual's continued loss of ambulatory ability was not adequately assessed by the Facility. During the discharge planning, dental issues were not addressed. Other Acute And Chronic Medical Issues, Not Adequately Addressed: • Individual #383: The following example indicates inadequate following up on cardiac and neuromotor conditions. Chest x-ray on 9/14/11 demonstrated mild cardiomegaly with mild congestive heart failure, new since 8/29/11. Recent	

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		EKG, dated 4/28/11 demonstrated bradycardia. There were no orders or notes addressing these diagnostic studies. Congestive heart failure, in the presence of bradycardia can be a lethal condition. The individual has scoliosis and was last evaluated by Orthopedics on 3/9/07, and was suppose to follow-up on 3/09; however, the individual did not follow-up with Orthopedics as recommended. Direct observation of the individual by the Monitoring Team noted possible spasticity and contractures; however, these conditions were not on the list of Individuals with spasticity. • Individual #336: The following example indicates failure to follow-up on laboratory data. This Individual had multiple hospitalizations for aspiration pneumonia in the past and was noted to have pseudomonas colonization, however, there was no follow-up by the Facility for this condition. On 6/24/11 the Individual was prescribed vancomycin 750 mg every 12 hours for 10 days. On 6/24/11, the Individual was to have both a peak and trough blood level for vancomycin; however, only the trough result was noted in the record and signed off by the physician on 6/27/11. The trough level was noted to be sub-therapeutic, however, a new order for vancomycin, written on 6/28/11, was for the exact same dose of the medication. The Monitoring Team could not find a Peak blood level, which would be necessary to adequately dose the Individual with vancomycin. The Individual required emergency hospitalization for worsening pneumonia on 7/1/11. • Individual #61: The following example indicates that behavior health management was not adequately incorporated into the medical care of this individual. The Individual was known by the Facility to self injure to the point of developing full thickness skin lesions. The Monitoring Team observed the Individual to have two large full thickness skin lesions. The Facility did not adequately protect this Individual by means of behavioral intervention, nor did the Facility provide adequate behavior management to promote health and administration of medical care for the lesions. The observed lesions were of significant medical concern. • Individual #20: The following example reflects lack of assertive follow-up for cancer surveillance, in a person who had cancer. The individual underwent a left mastectomy secondary to breast cancer in 2004. The last reported mammogram noted in the clinical record was 3/30/09, which was later than recommended. General Observations: The Medical Director reported to the Monitoring Team that the Facility will initiate a new process that will enhance the management of chronic medical conditions. The process will ensure that the clinician will evaluate the Individual every three months, specifically to address chronic care issues.	

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		Following its review, the Monitoring Team has determined that the Facility remains not in compliance with Provision L.1, of the Settlement Agreement because of its inability to ensure appropriate management of chronic health care conditions, participation in a team environment, and failure to appropriately assess for the etiology of underlying conditions. <u>Mock Medical Emergency Drills and Emergency Response</u> It was positive to find that since the last compliance review, the Facility had made significant improvements to the Mock Medical Emergency Drills and Emergency Response system. The improvements were verified through interviews with Deb Salsman, Director of Incident and Risk Management, Chuck Brookins, Security Officer, Jeron Dotson, Incident Management Coordinator, 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), and documents requested off-site and on-site. Also reviewed was a citation from the CMS 2567 Report, 6/7/2011; numerous changes to the emergency response procedures were made in response to the CMS 2567 Report. During the Monitoring Team's interview with the emergency response staff, they were asked if signs were posted throughout the Facility identifying the location of emergency equipment, staff related that signs were not posted. They agreed signs should be posted identifying the location of emergency equipment. Additionally, the need to record response time initially to and during the drill should be recorded on the Mock Medical Emergency Drill sheets. While it was not permissible to change items on the standardized drill sheets, the Facility should be able to add information they need on to the drill sheets. The Emergency Response improvements included the following activities: • Formalized a Drill Committee Policy and Procedure to include the following information: o Membership of the Committee included: ▪ Center Director ▪ Assistant Director of Programs ▪ Director of Quality Assurance ▪ Director of Risk/Incident Management ▪ CNE ▪ NOO ▪ Medical Director Safety Specialist ▪ QA Nurse o The Drill Committee will meet at least once a quarter. The Safety Specialist	

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		will complete and maintain minutes of all meetings. An electronic copy of the minutes will be distributed to all committee members. The completed minutes will be stored on the S:/drive in the Risk Management folder. • The Facility's need for additional emergency equipment and resources to ensure all areas had the necessary equipment and resources readily accessible to response to emergency situations was assessed. The needed emergency equipment was ordered. • The Safety and Security Services, Operating Instructions were revised to include instructions for a back-up security vehicle fully equipped with emergency equipment and a back-up security team to respond to simultaneous emergencies. All Security Officers were trained on the expectations during an emergency, which included brining the emergency equipment bag to the scene and then escorting the Emergency Medical Services to the scene. • Developed different scenarios used during CPR Drills, e/g., placing manikins in different areas outside and inside the Facility. • Began monthly and cumulative Mock Medical Emergency Drill Compliance Trending. Monthly trend results were represented by line graphs. Trend data from 1/2011 through 8/2011 indicated compliance with staff's drill performance ranged from 100% to 96%. Trend data was provided to the Quality Assurance Department. • Reported results of the completed Mock Medical Emergency Drills, including any corrective action taken at the Incident Management Review Team Meetings, as well as at the Fire Drill Committee Meeting. With the implementation of the recent Drill Committee Policy and Procedure, the results and any plans of correction will be reviewed and discussed at committee meetings. • The Quality Assurance Nurse, who was also a Certified CPR Drill Instructor, continued to conduct and oversee the quality and effectiveness of the drills. • A scribe was assigned to document response time to and during the drills in order to improve the timeliness of response during the drills. • Notebooks and pens were placed in all emergency kits that the Security staff brings to the scene of an emergency so that the response time can be documented, particularly in the event of a code, to ensure that time sequences of response to the event are accurately documented. • Review of the Mock Medical Emergency Drill Schedule for the past six months indicated that drills were completed according to schedule. If not, there was documentation that the Security Officer responsible for overseeing the drills notified the responsible staff for conducting the delinquent drill and followed up to ensure that the drills were conducted. • Review of the completed Mock Medical Emergency Drill sheet for the past six months, indicated there was documented evidence on the drill sheets that when staff failed to perform correctly they were re-trained "on the spot". Those staff, who failed to perform satisfactorily after "on the spot" re-training, was sent back to Competency	

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		Training and Development for retraining on CPR. • Physicians were beginning to participate in the Mock Medical Emergency Drills. • A list was developed and distributed identifying the location of all emergency equipment throughout the Facility. • In addition to the current practice of nurses checking for the presence of Ambu-bags, the Respiratory Therapist was made responsible for checking all Ambu-bags for good working order quarterly. • According to the Facility's POI, Section M.2, the nursing staff had received in-service training, 7/13/2011, on Critical Incident Team (CIT) Policy updates and Med-06 Life Threatening Emergency updates. The Section M Presentation Book included signed In-service Training Sheets for these training items. However, the percentage of nurses trained were not summarized and included in the Presentation Book. Therefore, the Monitoring Team was unable to determine the status of compliance with the training provided. The Facility had received and apparently implemented the State's revised Emergency Response, Policy Number: 044.2, dated: 9/7/2011. There was no training documentation available to review to determine the status of staff's training on this revised policy. The revised policy provided significantly improved and comprehensive instructions for emergency response procedures, as well as improved standardized forms for Emergency Drill Checklist, Emergency Oxygen Tank and Suction Machine Checklist, AED (Automated External Defibrillator), Emergency Bag Check Off Sheet, and Emergency Equipment Walkthrough Checklist. This revised policy should further assist the Facility with improving their emergency response system. As a result of the revised Emergency Response Policy, in addition to scenarios placing the manikin in various locations inside and outside the Facility, other scenarios should be considered to include emergency situations listed in the policy. A review of the CTD Due/Delinquent Training List for CPR for Health Care Providers and CPR: Basic, found that no staff were delinquent in CPR for Health Care Providers training but found eight staff were delinquent in CPR Basic training. A review of all required Emergency Equipment Checklists found that Security Equipment Verification Checklists were consistently completed daily and on all shifts. While there was noted improvement by the nursing staff in checking emergency equipment daily and on all shifts, as was found at the last compliance review, the Control Drug Check Sheets and Emergency Checklists were not consistently completed daily and/or on all shifts. As mentioned above, the amount of improvement the Facility had made in their	

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		emergency response system was impressive. As a result of the numerous improvements, the Facility has moved close to compliance with this requirement of the provision. Many of the improvements occurred in recent months and need time to mature in order to measure their effectiveness. In addition to maintaining the positive practices identified in the report, and in order to meet compliance with the requirement of this provision the Facility should consider making the following improvements: • Post signs throughout the Facility identifying the location of emergency equipment. • Add response time, initially and during the drills to the Mock Medical Emergency Drill form. • Ensure that all required staff remains current in CPR training. • Ensure that all required staff receives training on the revised Emergency Response Policy, 9/7/2011. • Ensure that when additional emergency response training is provided that the percentages of staff trained are tracked to ensure all required staff have completed the required training. The results of the trainings completed should be reported in the Drill Committee minutes and/or in other relevant reports. • Ensure that the nursing staff consistently checks all Control Drug Check Sheets Emergency Equipment according to Facility policy. The Drill Committee should also review and analyze the emergency equipment to identify problems/trend resulting from incomplete checks of emergency equipment and develop CAPs when appropriate.	
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.	While on-site, the Monitoring Team reviewed the Facility's process for maintaining a medical review system to facilitate quality medical care and clinician performance. The Facility participated in the DADS Medical Provider Quality Assurance Audits. The Facility underwent its most recent audit in August, 2011, and the last ten audits from that review were assessed by the Monitoring Team. The Audits were noted to be complete, and appropriate follow-up was initiated for each identified deficit. Although the DADS Medical Provider Quality Assurance Audit is an excellent tool and enables an effective process for assessing physicians' compliance with operational needs, such as policies, procedures, and acceptable documentation practices, the process does not assess clinical competency, hence, does not enable a meaningful assessment of a physician's clinical performance. It is the Monitoring Teams understanding that DADS is in the process of enhancing the Medical Provider Quality Assurance Audits to include performance standards. For this reason, the Monitoring Team concurs with the Facility's self-assessment and determined that the Facility remains noncompliant with Provision L.2, of the Settlement Agreement. Since the last Monitoring Team's compliance review, it was positive to find that the	Noncompliance

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		Facility had made significant improvements in their death review process. The Nurse Investigator had developed and implemented a comprehensive tracking system for Death Review Compliance, Clinical Death Review and Administrative Death Review Recommendation Tracking Logs. Relevant to the requirements of this provision, the Facility had contracted with an external physician for Quality Assurance, who reviewed death related reports and participated in the Clinical Death Review Committee Meetings. Findings of these reviews are found in Provision L.3. The Facility had established a medical review system involving non-Facility physician medical and mortality case reviews and assistance. In general, although the DADS Medical Provider Quality Assurance Audit is an excellent tool and enables an effective process for assessing physicians compliance with operational needs, such as policies, procedures, and acceptable documentation practices, the process does not assess clinical competency, hence, does not enable a meaningful assessment of a physicians clinical performance. It is the Monitoring Teams understanding that DADS is in the process of enhancing the Medical Provider Quality Assurance Audits to include performance standards. The Monitoring Team concurs with the Facility's self-assessment and determined that the Facility remains non-compliant with Provision L.2, of the Settlement Agreement. To achieve compliance, the review system will need to be enhanced so that it addresses and helps to improve quality of medical care.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	The Facility has a dedicated physician assigned to the medical quality assurance process at the Facility. The Facility does not have a local policy or procedure delineating this process. Clinical indicators had not been clearly identified and there was no data analysis conducted for trends analysis. For these reasons, the Monitoring Team concurs with the Facility's self-assessment and determined that they remain non-compliant with Provision L.3, of the Settlement Agreement. The Monitoring Team does, however, recognize that the Facility had conducted quarterly internal audits, using the DADS Medical Provider Quality Assurance Audit tool. Importantly, in addition to identifying issues per the audit tool, the QA physician also reviews for outstanding clinical issues, such as assessing the management of acute care, and efficacy of the treatment for chronic conditions. The Facility is in the process of working with DADS to develop and implement a formal medical quality improvement process that collects data relating to the quality of medical services, as required by the Settlement Agreement. The Monitoring Team also noted marked improvement with the Facility's mortality review process. The Facility developed a new local policy, the Clinical Death Review Committee" policy, which clearly outlines the process and expectation of the mortality review process and committee function. The new policy is in line with current standard	Noncompliance

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		practice for mortality review. The Facility also ensures that external physicians are involved in the review process and that identified concerns are translated into action plans, that are tracked until resolution. The Monitoring Team reviewed the most recent three mortality review cases and noted that they were completed timely and appropriately. A review of the Clinical Death Review Committee Meeting Minutes for the 10 deaths revealed the following: • Nine of the 10 (90%) Clinical Death Review Committee Meetings Minutes showed that an external physician was present at the meetings. • Ten of the 10 (100%) Clinical Death Review Committee Meetings Minutes showed that the Facility met all of the other Clinical Death Review Policy requirements. • The Clinical Death Review Committee Meetings Minutes and related reports (Death/Discharge Summaries and Unusual Incident Investigations) showed progressive improvement in critical thinking, in-depth discussion, as well as appropriate recommendations that included not only ones related to the immediate circumstance at the time of death but also began to include systemic recommendations. Most notable improvements were found in the reviews for deaths occurring after May 2011. • The Clinical Death Review Recommendation Tracking Log indicated that all recommendations were completed except for some of the last three deaths, which were not yet due. A review of the Administrative Death Review Committee Meetings for the 10 deaths revealed the following: • Ten of the 10 (100%) Administrative Death Committee Meetings met all of the Administrative Death Review Policy requirements. • The Administrative Death Committee Meeting Minutes also showed progressive improvements in critical thinking, in-depth discussion, as well as appropriate recommendations that included not only ones related to the immediate circumstance at the time of death but also began to include systemic recommendations. • The Administrative Death Review Recommendation Tracking Log indicated that all recommendations were completed except for some of the last three deaths, which were not yet due. Since the Monitoring Team's last compliance review, there have been 10 deaths of individuals that DSSLC supported. Of these, one had an autopsy completed, and all had both clinical and administrative death reviews completed. A copy of the death certificate	

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		had not been received on the most resent three deaths. The age range of those who died was 32 to 75 and the average age was 62. Primary causes of deaths included the following: respiratory system associated death (aspiration pneumonia/pneumonia) in five cases; cardiopulmonary arrest in one case; death occurring in less than 24 hours from onset of symptoms, not otherwise explained; malignant lymphomas in one case; and preliminary causes of death respiratory system associated deaths (aspiration pneumonia/pneumonia) in tow cases. This indicated that 70% were respiratory system associated deaths. The high number of incidents related to respiratory system associated (aspiration pneumonia/pneumonia) deaths suggested the need for continued vigilance in early recognitions. This should include at minimum: Close monitoring by all responsible disciplines of individuals identified at high and medium risk for respiratory system associated problems to ensure there is proper positioning; timely respiratory therapy; efficient communication between direct care professionals and nursing staff; comprehensive nursing assessments; and prompt notification of providers (physicians/nurse practitioners) of changes in status; and early diagnoses and treatments by the providers. The Medical and Nursing Departments and Nurse Investigator should develop a list of critical questions to answer in reviewing each decedent's medical record. This might improve the scope and depth of clinical discussions and recommendations, as well as provide consistency among the reviewers. Despite rating the Facility non-compliant with the Provision, the Monitoring Team clearly recognizes the many improvements made in the area of medical quality assurance. Identifying data elements for clinical outcomes of common and serious medical conditions, based on clinical standards of care, and comparing to the clinical outcomes achieved by the Facility, would help to enable compliance.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly	At the time of this review, the Medical Director reported that the Facility continues to await further direction from DADS on the development and implementation of Clinical Pathways, and have yet to develop a process to facilitate generally accepted professional standards of care. Given that a process has yet to be developed and implemented by the Facility, the Monitoring Team concurs with the Facility and determined that the Facility remains not in compliance with Provision L.4, of the Settlement Agreement.	Noncompliance

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	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.		

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

1. Improve the clinical management of persons with chronic neuromotor, musculoskeletal and orthopedic conditions. Issues that must be addressed include documenting the appropriate diagnosis for each condition, ensure that necessary consultations and diagnostics are routinely obtained, ensure that maintenance PT and OT is provided, and ensure to regularly assess for functional decline, secondary to the condition or associated condition.
2. Ensure that the PSP includes discussion about and identification of necessary supports and services for all chronic medical conditions.
3. Improve the clinical management of persons with PKU. Clinical rationale must be clearly delineated if treatment deviates from a standard of care approach.
4. Implement an integrated approach to the management of DM, that takes into account medical, dietary, and physical therapy. In addition, diabetes education should be provided routinely to the Individual, staff, and family members. Psychosocial and behavioral management should also be well incorporated in a comprehensive treatment program for DM.
5. OT/PT services must enhance physical assessments and provide more meaningful recommendations to the team. OT/PT must document the diagnosis of each condition they assess and treat and maintenance OT/PT must be offered to persons with chronic conditions that affect physical and cognitive abilities
6. Implement a comprehensive list all acute and chronic medical conditions.
7. Immediately ensure that nursing staff are aware the Facility's procedure for calibrating glucometers.
8. Immediately enhance the monitoring of persons who require positioning, especially when provided enteric tube feeding. It would be advantageous if physician would periodically assess Individuals at the living area to ensure their recommendations on positioning and feeding are being followed.
9. Immediately develop and implement a process to track and follow-up on all cases of pneumonia at the Facility.
10. Ensure that all health care issues requiring specialized supports and services are adequately identified in the CLDP and reported to Community Living Agencies
11. Post signs throughout the Facility to identify the location of emergency equipment.
12. Add response time, initially and during the drills to the Mock Medical Emergency Drill form.
13. Ensure that the nursing staff consistently checks all Control Drug Check Sheets Emergency Equipment according to Facility policy. The Drill Committee should also review and analyze the emergency equipment to identify problems/trend resulting from incomplete checks of emergency equipment and develop CAPs when appropriate.
14. Collaborate with DADS to ensure that the Medical Provider Quality Assurance Audit process includes a method to assess clinical performance abilities by Physicians
15. The high number of incidents related to respiratory system associated (aspiration pneumonia/pneumonia) deaths suggested the need for the Facility to ensure continued vigilance for early recognition.
16. The Medical and Nursing Departments and Nurse Investigator should develop a list of critical questions to answer in reviewing each decedent's medical record. This might improve the scope and depth of clinical discussions and recommendations, as well as provide consistency among the reviewers.

17. Develop and Implement a medical quality assurance process that utilizes clinical outcomes data for trends analysis.

The following are offered as additional suggestions to the facility:

1. Consider utilizing multi-patient, self calibrating, data storing/transmitting glucometers. Personal glucometers could continue to be used for outings.

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Plan of Improvement (POI), 9/7/2011 2. DSSLC Settlement Agreement – Section M Presentation Book 3. DSSLC Policy: Quality Assurance (QA)/Quality Improvement (QI) Council, Policy Number: Committees and Councils -02, Date: 9/29/2010, Revised: 9/6/2011 4. DSSLC Nursing Division: Nursing Protocol: Glucometer Quality Control (QC), Date: 9/20/2011 5. DSSLC Infection Control Committee, Policies and Procedures Manual, Policy Number: Committees and Councils–11. Date: 3/1/2009 6. DSSLC Infection Control – Antibiogram Procedure, Revised: 9/22/2011 7. DSSLC Nursing Division: Surveillance Policy, no date 8. DSSLC Policy: Reporting Employee Absence Policy, no date 9. DSSLC Policy: Infection Control Practices for an Influx of Infectious Individuals, Review/Revision Date: 8/2/2011 10. DSSLC Division of Nursing: MDRO (Multi-Drug Resistant Organisms) Policy, Date: 8/15/2011 11. DADS Policy: Emergency Response, Policy Number: 044.2, Effective: 9/7/2011, Replaces: 044.1 12. DSSLC Safety and Security Services, Operating Instructions, no date 13. DSSLC Policy: Drill Committee, Committees and Councils–10, Date: 9/19/2011 14. DSSLC Nursing Organizational Chart 15. DSSLC Nursing Meeting Minutes, 7/2011 and 8/2011 16. DSSLC Personal Support Plan (PSP) Schedule 17. DSSLC Budgeted, Filled and Unfilled Positions, 7/31/11 18. DSSLC Nursing Budgeted, Filled and Vacant Positions, Updated: 9/19/2011 19. DSSLC Nursing Desired Staffing Summary for past six months 20. DSSLC 24-Hour Nursing Reports for 6/2011 and 7/2011 21. DSSLC Admission Activity, 4/1/2011 through 8/15/2011 22. DSSLC Emergency Room Report, 2/27/2011 through 8/27/2011 23. DSSLC Hospital Admissions, 4/2/2011 through 8/24/2011 24. DSSLC Infirmary Census and Hospital Report, 9/16/2011 25. DSSLC Morning Meeting Notes/Log – Westridge Unit, 9/21/2011 26. DSSLC Tracking Decubitus Report – Unresolved, 9/19/2011 27. DSSLC Health Risk (High) Report, 8/24/2011 28. DSSLC Hospital Nurse Liaison Daily Agenda 29. DSSLC Summary Report of Trend Analysis of Infectious Disease/Communicable Disease for past Two Quarters 30. DSSLC Infection Control – Scabies Control Measures Instructions and Staff Training Log, 9/15/2011 31. DSSLC Infection Control – Home Shift Log for Apartment 14C, Nursing Instructions for Direct Care Professional Regarding Scabies Control Measures, 9/6/2011 and 9/23/2011 32. DSSLC Infection Control Preventionist Nurse's Records for Individual #14 33. DSSLC Infection Control Preventionist Nurse's Duties and Responsibilities 34. DSSLC Infection Control Monitoring Tools with Instructions: Infection Control Surveillance, Infection

	Control Rounds, and Handwashing Monitoring 35. DSSLC Infection Control Surveillance Reports, 7/2011 through 8/2011 36. DSSLC Infection Control – Client Services Oversight Monitoring Reports, 7/3/2011 through 8/2011 37. DSSLC Infection Control – Handwashing Monitoring Reports, 8/2011 38. DSSLC Infection Control Rounds, 8/2011 39. DSSLC Infection Control Training Manual 40. DSSLC Infection Control Committee Reports, 1/2011 through 3/2011 and 4/2011 through 6/2011 41. DSSLC Communicable Diseases by Selected Codes Reports, 1/1/2011 through 7/31/2011 42. DSSLC Epidemiology Reports, 4/2011 through 6/2011 and 7/2011 43. Regional Clinical Laboratory Epidemiology Report, 8/1/2011 through 8/31/2011 44. DSSLC Client Services Oversight Monitoring, 7/2011 through 8/2011 45. DSSLC Environmental Review Team Meeting Minutes, 7/2011 and 8/2011 46. DSSLC Quality Assurance Plan, Printed: 9/20/2011 47. DSSLC QA/QI Quarterly Review Information, Revised: 9/9/2011 48. DSSLC QA/QI Council Meeting: Data Analysis Report, Sections I, J, K, O, P, Q, and M, 7/21/2011 49. DSSLC Nursing Monitoring Instrument Plan for Settlement Agreement - Section M, Revised: 8/19/2011 50. DSSLC Nursing Care Monitoring Tool Monthly, Quarterly, and Year to Date Reports, 3/2011 through 8/2011 51. Department of Health and Human Services Center for Medicare and Medicaid Services, Provider Identification Number: 45G004, Form CMS-2567, Printed: 6/21/2011 52. DSSLC Fire Drill Meeting Minutes, 3/1/2011, 6/17/2011, and 9/2/2011 53. DSSLC Incident Management Review Team Meeting Notes/Logs, 8/17/2011, 8/26/2011, 8/29/2011, 8/30/2011, and 8/31/2011 54. DSSLC Different Scenarios Used During Cardiopulmonary Resuscitation (CPR) Drills 55. DSSLC Medical Emergency Drill Compliance Trending Report, 1/11/2011 through 8/31/2011 56. DSSLC List of Staff Responsible for Conducting, Reporting, and Tracking Mock Medical Emergency Drills 57. DSSLC Facility List Identifying the Location of all Emergency Equipment 58. DSSLC Mock Medical Emergency Drill Monthly Schedules for past six months 59. DSSLC Completed Mock Medical Emergency Drill Sheets for past six months 60. DSSLC Completed Emergency Equipment Checklists for the 7/2011 and 8/2011 61. DSSLC Course Due/Delinquent Training List for Course: CPR0100 – CPR: Basic, Printed: 8/22/2011 62. DSSLC Course Due/Delinquent Training List for Course: CPR0250 – Basic Life Support (BLS) for Health Care Providers, Printed: 8/22/2011 63. DSSLC Nursing Standardized Procedures-Protocols-Guideline Training Tracking Log 64. DSSLC Medication Administration Observation Reports 3/2011 through 8/2011 65. DSSLC Pharmacy and Therapeutics Committee Meeting Minutes, 3/9/2011, 3/29/2011, 4/26/2011, 5/24/2011, 6/28/2011, 7/26/2011, and 9/2/2011 66. DSSLC Ten Most Recent Medication Error Reports 67. DSSLC Medication Protocol – Draft (for Calcium, Multivitamins, Iron, Antacid, and Magnesium) 68. DSSLC Medication Error Trend Reports for 2/2011 through 8/2011

	69. DSSLC Hospital Nurse Liaisons' Sample Records for Current Hospitalized Individuals: #524, #42, #336, #228, #18, and #552 70. DSSLC Wound Care Nurse's Sample Records for Individual #3 71. DSSLC Diabetic Educator's Sample Records for Individuals: #505, #367, #89, #560, #517, #335, #331, #19, and #402 72. Records reviewed for Individuals: #11, #279, #580, #697, #3, #642, #657, #601, #776, #478, #352, #537, #291, #438, #498, #409, #217, and #349, #526, #191, and #119 **People Interviewed:** 1. Delia Schilder, RN, Chief Nurse Executive (CNE) 2. Sherri Courtney, RN, Nursing Operations Officer (NOO) 3. Sibylle Graviett, RN, Nurse Case Management Supervisor 4. Johanna Hayse, RN, Wound Care/Educator/Specialty Nurses' Supervisor 5. Diane Porter, RN, Diabetic Educator 6. Sharon Lancaster, RN, Hospital Liaison 7. Amber Shotts, RN, Hospital Liaison 8. Maria Pangilinan, RN, Infection Control Preventionist Nurse 9. Linda Barnett, RN, Nurse Educator 10. Gwen Weiss, RN, Nurse Educator 11. Emergency Response Committee Members, 9/19/2011 • Deb Salsman, Director of Incident and Risk Management • Chuck Brookins, Security Officer • Jeron Dotson, Incident Management Coordinator • Allana Garrison, RN, Quality Assurance Nurse Supervisor • David Anderson, Assistant Security Officer • Delia Schilder, RN, Chief Nurse Executive (CNE) • Sherri Courtney, RN, Nursing Operations Officer (NOO) **Meetings Attended/Observations:** 1. Infirmary Morning Rounds, 9/20/2011 2. Annual PSP for Individual #61, 9/20/2011 3. At Risk-PST Team Meeting for Individual #306, 9/20/2011 4. QA/QI Meeting, 9/20/11 5. Medication Variance Meeting, 9/20/2011 6. Pharmacy and Therapeutic Meeting, 9/21/2011 7. Meeting with Three Groups of RN Case Managers, RN Case Manager Supervisor, CNE, and NOO, 9/21/2011. RN Case Managers included: • Mary Harrison, RN – Cedar Falls • Isabella Mall, RN – Cedar Falls • Tami Selby, RN – Cedar Falls • Patti Land, RN – Houston Park • Carol Schellenberg, RN – Westridge • Diane Parkins, RN – Garden Ridge

	• Rosie Otiono-Obesaki, RN – Eastfield • Frances Rowlett, RN – Pine Ridge • John Muiru, RN – Garden Ridge • Jay Mathews, RN - Westridge 8. Observed Wound Care for Individual #228, 9/22/11 9. At Risk-PSP Team Meeting for Individual #102, 9/22/2011 10. Medication Administration Observations in Building 528 for A, B, C, and D Apartments, 9/22/2011
	Facility Self-Assessment: The Facility's Plan of Improvement, updated 9/7/2011, provided comments and status for Sections M.1 through M.6 of the Settlement Agreement. The Facility indicated it was in noncompliance with Provisions M.1 through M.6. This was consistent with the Monitoring Team's findings as all provisions were found to be noncompliant. The Facility's Self-Assessment information reported was inadequate to determine the progress made toward compliance for all provisions. The data included in the Facility's POI contained activities repeated in past compliance reviews as well as activities completed since the last compliance review. The information provided for the various provisions did not always relate to the Settlement Agreement requirements for the specific provisions. There were no analyzed and summarized data contained in the self-assessment data that indicated how those activities were moving the Facility toward compliance within the respective provisions. There was no clear sequential framework or timelines established to identify how they expected to reach compliance. The Facility needs to ensure that the activities and action steps included in the POI reflect the requirements set forth in the Settlement Agreement for that specific provision. Through review of the Presentation Book for Section M, interviews, and observations the Monitoring Team was able to validate the activities listed in the Facility's Self-Assessment were carried out; and in some case showed improvement in moving the Facility toward compliance for some of the provisions. Some of the primary improvements made were: The realignment of two License Vocational Nurse positions to Registered Nurse positions for the Infirmary to provide higher level skilled nurses to provide care to medically complex individuals. The hiring of a new Infection Control Preventionist Nurse to manage the Infection Control Program. The Emergency Response System had made significant improvements in completing and analyzing Mock Medical Emergency Drill. Data derived from the drill were critiqued in the Emergency Response Committee and plans of correction were taken when indicated. The Facility had implemented a Medication Variance Committee to review all medication administration practices. Other activities and improvements were discussed in the Monitor's Assessment and throughout the report.
	Summary of Monitor's Assessment: Provision M.1: This provision was determined not to be in compliance. The Nursing Department continued to demonstrate a high degree of enthusiasm and commitment to moving toward compliance with all provisions of the Settlement Agreement.

	DSSLC's Nursing Department had essentially remained stable since the last compliance review. Several staffing realignments were made to improve nursing services. Two vacant Licensed Vocational Nurse position were reallocated to Registered Nurse positions and placed in the Infirmary to provide higher level skilled nurses to manage the care of medically complex individuals. A new Infection Control Preventionist was hired to manage the Infection Control Program. This nurse had made significant improvements in the Infection Control Program since being hired. The Infection Control Department and Pharmacy Department had begun to monitor antibiotic prescribing practices; this meets the Settlement Agreement and Health Care Guidelines requirements. Although there were several nursing vacancies, requiring the continued use of agency nurses, the CNE was actively recruiting to fill and retrain the vacant positions. This requirement was close to meeting compliance with the Settlement Agreement. There was consistent use of the SOAP format for documentation. The P (plan), with rare exception, indicated what would be followed-up on as opposed to simply stating "will continue to monitor" as was noted in past compliance reviews. Changes in individuals' health status were better recognized and assessments completed with prompt notification of findings reported to the providers (physicians and nurse practitioners). The requirement for the management of acute changes in status had improved since the last compliance review but there remained opportunities for continued improvement for all aspects of managing and documenting care according to the Acute Illness and Injury Protocols, as described in the report. The Nursing Care Monitoring Tools were being completed and the data were beginning to be analyzed and corrective action plans established. A problem identified that needs to be resolved was the lack of weighting the significance of each item on the tools. Items of less significance were weighted the same as those of critical importance. The process of inter-rater reliability monitoring was still being refined and was not fully implemented to yield reliable data. It was commendable that there were no more than two individuals found with decubitus ulcers considering the Facility's large a population with many individuals being medically fragile. This was no doubt attributable to the competent skills and commitment of the Wound Care Nurse and her efforts to ensure integrated care though collaboration with other disciplines. The Facility's Emergency Response System had made significant improvements. Mock Medical Emergency Drills were more consistently conducted; the drill data were being tracked, analyzed, and trended. An Emergency Response Committee was fully operational and was reviewing the data from the drills and other emergency response issues and making corrective action plans when indicated. The Facility identified and had ordered addition emergency equipment to ensure that all areas had the necessary emergency equipment. The Emergency Response System was continuing to refine its processes and was close to meeting compliance with this requirement of the Settlement Agreement. Provision M.2: This provision was determined not to be in compliance. Although great strides had been

	made to improve the quality of the nursing assessments, the nursing summaries need continued improvement to critically analyze clinical data derived from the assessments, for each identified nursing problem/diagnosis, to accurately reflect whether individuals' health status was improving, maintaining, or regressing. As the RNs complete the Physical Assessment Class, their enhanced knowledge and skills should improve nurses' ability to critically analyze clinical data and summarize it to accurately reflect individuals' health status. Provision M.3: This provision was determined not to be in compliance. It was apparent that much effort had been put forth to improve the quality of the health care plans. However, they continued to lack adequate individualization to meet individuals' specific problems. Their plans did not demonstrate integration with other disciplines to meet the total needs of individuals. The Nursing Department needs to continue to individualize health care plans, collaborate with other relevant disciplines in developing plans, and ensure the plans include the frequency of interventions/actions to be carried out, by whom, when and where to document interventions/actions carried out. The effectiveness of the plans need to be evaluated when the goals/objectives are not met to prevent or minimized the identified problems. Provision M.4: This provision was determined not to be in compliance. There was evidence that all core State and Facility nursing policies, procedures, and processes, had been finalized. The Nurse Educators maintained an excellent tracking database and were able to validate that 97% to 100% of the nursing staff had been trained in the core policies, procedures, and processes. The Nurse Educators were using the Nurse Education Handbook for new nurse orientation. The nursing orientation program had been expanded to six weeks. The Preceptor Program for mentoring new nurses had been revised and strengthened. The Nurse Educators had implemented the Clinical Indicators of Health Status Change Class at New Employee Orientation and were also providing training to recumbent staff. This provision was close to meeting compliance. Provision M.5: This provision was determined not be in compliance. The nursing staff had been trained on the At Risk Individual Policy and Procedures and the Aspiration Tracking Tool. The RN case managers were completing the heath/medical risk criteria and presenting their findings at the At Risk meeting for PST to review and rate levels of risk. The nurses need to collaborate with the physicians who hold joint responsibility for completing the health/medical risk assessments, as well as with other relevant disciplines to ensure that all related health/medical issues were identified and considered in determining risk ratings before the risk assessments were presented at the At Risk meetings for the PSTs to review. This was an evolving process and was too soon to determine the status of compliance. Provision M.6: This provision was determined not to be in compliance. However, this provision had made significant progress toward compliance. The Facility continued to provide individuals with privacy during medication administration. The direct care professionals assisted the nurses during medication administration to reduce distractions in an effort to reduce the incidents of medication errors. The Facility had developed and implemented a comprehensive Medication Error Database to track, analyze and trend medication errors using a root cause analysis approach. The medication error data were being utilized to identify areas of practice for which corrective action plans were needed to reduce the incidents of

	medication errors. While compliance was not met much progress had been made toward achieving compliance with this provision.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	The Facility's POI stated they were not in compliance with this provision and the Monitoring Team concurs. According to the Facility's POI for Section M.1, since the last compliance review, the Nursing Department reported the following activities: Began a plan to increase the percentage of nursing position fill rates. Reallocated two vacant Licensed Vocational Nurse (LVN) positions to Registered Nurse (RN) positions. Nursing Administration had begun addressing the need for individualized health care plans with RN case managers. Begun developing a process for information discussed with staff on health care plans to be documented in individual progress notes. Supporting documentation to validate these activities was contained in Section M Presentation Book. <u>Staffing</u> At the time of the compliance review, DSSLC had a census of 518 individuals. Since the last review, DSSLC continue to have 87 positions allocated for Registered Nurses (RNs), and 133 positions for Licensed Vocational Nurses (LVNs), with 83% of the RN positions filled and 77% of the LVN positions filled. According to the CNE, 10 nurses were currently in orientation. On 7/1/2011, two vacant LVN positions in the Infirmary were reallocated to RN positions. This reallocation was made to provide higher level skilled nurses in the Infirmary due to the high acuity of individuals admitted to the Infirmary. On 6/1/2011, it was positive to find that the Nursing Department had hired a new Infection Control Preventionist Nurse with three years experience working as in Infection Control Nurse at Integrity Transitional Hospital. It was also positive to find that that on 7/19/2011, the Facility contracted with an Infectious Disease Physician to provide consultation on infection control issues, e.g., assist with revision of infection control policies and procedures, consult with medical provider regarding antibiotic use, and provide relevant clinical staff with training on infectious disease processes and management. In spite of the vacancies, primarily for direct care nurses, the Nursing Department had remained stable. The Nursing Administration and Management Nurses continued to be highly motivated and dedicated to providing high quality nursing services. The Nursing Department was fortunate to have experienced and competent specialty nurses, e.g., Wound Care Nurse, Diabetic Educator, two Nurse Educators, two Hospital Liaison Nurses, and Infection Control Nurse. This was demonstrated through interview and	Noncompliance

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		record reviews of their documented assessments and management of conditions related to their area of expertise, as well as evidence of collaboration with other relevant disciplines. Please refer to information reported below in this section related to specialty areas of nursing practice. The CNE reported that established nursing ratios for the units and Infirmary were monitored daily on each shift. A review of the nursing ratios reports for past six months indicated that the nursing ratios were occasionally not met. The CNE stated there had been a further reduction in the use of agency nurses but, with the vacancies, the Nursing Department continued to use agency nurses to offset shortages in staffing. The CNE reported that recruiting and retaining nurses continued to be challenges due to: Facility's transition to once a month hiring, extended nursing orientation period, and the geographic location and distance required to drive to the Facility, compounded with high gasoline prices. Regardless of the challenge, the CNE continued to actively recruit nursing personnel, work on efforts to enhance retention, and evaluate the need to reallocate nursing positions to better meet individuals' nursing care needs, as well as the requirements of the Settlement Agreement. Refer to M.4 for retention efforts made through the use of a preceptor program. In order to meet compliance with the requirements of this provision, positive practices identified in the report must be maintained, and the other improvements should be made. The Nursing Department should consider making the following staffing improvements: • Continue to actively recruit and retain full time nursing positions and reduce or eliminate the use of agency nurses. • Ensure that established nursing ratios for the units and Infirmary are consistently met. <u>Quality Assurance Efforts</u> It was apparent from interviews with the CNE and other Nursing Administration and Management staff that the Nursing Department was consistently refining and improving their Monitoring Instrument Plan for Settlement Agreement for Nursing (SAN) for use of the 12 Nursing Care Monitoring Tools. The CNE continued to chair the SAN monitoring process with section leaders assigned to oversee each of the 12 Nursing Care Monitoring Tools. The RN Case Managers were assigned to complete the monitoring tools. Each RN Case Manager completed each of the 12 monitoring tools monthly for a total of approximately 28 individuals' records or a 5% sample of the census at the time of the review. The sample records were selected by the Quality Assurance Department's random sampling system. The completed monitoring tools were submitted to the Data Analyst to enter into the database for analysis and trending. Copies of the completed monitoring tools were provided to the section leaders and RN Case Managers to review	

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		and analyze for localized trends, and to draft corrective action plans for identified deficiencies. The monitoring data results were discussed at the monthly SAN follow-up meetings. According to the SAN Plan, the section leaders completed one monitoring tool for their section at least every other month for inter-rater reliability purposes and turned them in for processing. It was not clear how the inter-rater monitoring data was processed or used since the plan did not include the methods used to evaluate the effectiveness of the process. There were no inter-rater reliability data available for the Monitoring Team's review. The Facility had a formalized process for writing corrective action plans (CAPs). Data from the monitoring tools was set for an 80% compliance rating. A CAP was required for item(s) on the monitoring tools that fell below 80%. An additional CAP was required if the items that fell below 80% had not showed any improvement for two months. A CAP can be requested at any time at the discretion of the QA/QI Council. The reports generated from the QA database were comprehensive, well organized, and provided detailed information for each section's monitoring tools. Trend data derived from the database included the following: information: • Timeframe from which the data was collected. • Data was analyzed and trended by month, quarter and cumulative to date, e.g., rolling 12-month. • Name of the monitoring tool from which the data was analyzed and trended. • Total number of tools completed for each monitoring tool analyzed, including the number of tools completed by department staff as well as number completed by the QA staff. • Identified the percentage of the random sample size based on the Facility census at the time monitoring occurred. • Represented the percentage of compliance for each item on the tool, as well as overall percentage of compliance with the tool by line and/or bar graphs. • Provided a narrative explanation describing the overall percentage average for the reporting period, as well as narratives for areas showing significant improvement and those showing significant regression. It was positive to find the high degree of detail the QA system had generated in analyzing and trending data derived from the results of the monitoring tools. By providing this level of detail in the report the sections can measure progress or regression toward compliance for each monitoring tool as well their individual data items. From this information the sections and the QA/QI Council should be able to make rational decisions	

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		regarding areas that need to have systemic CAPs developed and implemented. After the Monitoring Team reviewed the monitoring trend data for the Nursing Care Monitoring Tools, it was realized that the data items on the monitoring tools were not weighted by value of significance. Therefore, when preparing overall compliance reports for the tools, the most critical data item counts the same as the least significant. According to the QA Plan requirements, each data item on the monitoring tools falling below 80% compliance required a CAP. Since the last compliance review, more data items reported longitudinal trends from the Nursing Care Monitoring Tools for the reporting period of 1/2011 through 6/2011. The QA/QI Council, which was comprised of each section leader, as well as other Facility administrative/management staff, met quarterly to review and discuss the longitudinal trend data derived from the various sections' monitoring tools. The Monitoring Team attended the QA/QI Council's quarterly meeting on 9/20/2011. The discussion of data trends associated with the Settlement Agreement's Section M monitoring tools was limited to addressing data items that showed progress or regression. There was no problem solving discussion generated in response to nursing's data items showing regression. Problem solving discussions were apparently left up to the SAN workgroup, as previously described above. The Facility reported that all 12 Nursing Care Monitoring Tools were being completed monthly and reported to the QA/QI Council on a rotation; only the trend data for the tools listed below were presented at this meeting of the QA/QI Council. They included: • Annual Nursing Care Plans - overall compliance 94.9% • Management of Chronic Respiratory Distress - overall compliance 94.1% • Seizure Management - overall compliance 92.1% • Skin Integrity - overall compliance 94.1% The monitoring process and development of outcome data for Section M of the Settlement Agreement continued to make progress since the last compliance review. The process was still maturing but should soon provide comprehensive measurement of outcomes toward compliance with all provisions. The State Office had developed guidelines for completing the Nursing Care Monitoring Tools; they were primarily references to the Settlement Agreement and Health Care Guidelines. While useful, they did not provide specific instructions to ensure consistency in ratings between the auditors. Consequently, without specific instructions, compliance ratings may be determined by each auditor's clinical judgment. Therefore, the outcome data for the ratings may be skewed, rendering it unreliable. The Nursing Department was completing inter-rater reliability check but there was no monitoring data available	

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		to review. Guidelines for the inter-rater reliability process needs to be clearly defined to ensure there is consistency between the raters. In addition to maintaining the positive practices identified in the report, in order to meet compliance with the requirement of this provision the Nursing Department should consider making the following improvements: • Ensure that all nursing auditors rating the monitoring tools are clinically competent and that there is consistency between auditors. Collaborate with the Quality Assurance Department to develop a formal method for conducting inter-rater reliability checks and to measure the effectiveness of the process. • Collaborate with the State Office to develop specific instructions for each of the Nursing Care Monitoring Tools. • Collaborate with the Quality Assurance Department and State Office to develop a system for "weighting" each data item on the monitoring tools by value of significance, where appropriate. This will aid in prioritizing the most critical items that need CAPs. • Develop CAPs for specific problems identified through monitoring specific units, shifts and/or other localized situations, as well as CAPs for systemic problems identified through the broader analysis of trend data. <u>Assessment and Documentation of Individuals with Acute Changes In Status</u> A review of eight individuals' active medical records (Individuals: #11, #352, #642, #601, #537, #119, #776, and #3) revealed, in general, there was significant improvement in following the Acute Illness and Injury and Documentation Protocols. <u>Areas that show improvement:</u> • There was consistent use of the SOAP format for documentation. The P (plan), with rare exception, indicated what would be followed-up on as opposed to simply stating "will continue to monitor" as was noted in past compliance reviews. • Changes in individuals' health status were better recognized and assessments completed with prompt notification of findings reported to the providers (physicians and nurse practitioners). When related to problems of the respiratory and gastrointestinal systems, lung and bowel sounds were consistently assessed. • Individuals with changes in status related to acute illnesses and injuries were better followed-up. Individuals' level of comfort or discomfort and mental status were usually included in the assessments completed related to the illnesses or injuries. • Individuals' response to antibiotic therapy and pain medication were more consistently addressed. <u>Areas that did not show significant improvement:</u>	

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		• Inconsistent completion of a full set of vital signs when assessing individuals' response to antibiotic therapy or when assessing for other changes in status. Often only the temperature was taken. In order to adequately assess vital signs all measurements must be assessed, e.g., temperature, pulse, respiration, blood pressure, and oxygen saturation. • Inconsistent documentation of the method temperatures were taken. Due to the variation in degrees of temperatures taken by different methods the method the temperatures were taken must be considered in order to accurately interpret the measurements,. • Integrated Progress Notes did not consistently include the time the notes were written. • Handwriting legibility continued to be poor. • There was a lack of documentation in the Integrated Progress Notes when Health Management and Acute Care Plans were initiated or that the direct care professionals were trained on the plans. Nursing interventions/actions contained in the plans and their effectiveness were not documented in the records. Although there was evidence that individuals' were followed up on according to protocol for acute illness and injury, a resolution note was not consistently documented. • With the exception of documentation by the Wound Care Nurse, Diabetic Educator Nurse, and Infection Control Preventionist Nurse, it was rare to find collaboration with other disciplines documented in the records. • The precise description of wounds, bruises, drainage, and emesis was not consistently documented. Although improvements were noted through interviews, record reviews, and observations the Nursing Department needs to ensure that the positive practices are maintained and continued to be strengthened to meet compliance with this requirement. <u>Hospital Liaison Nurses' Activities</u> It was positive to find since the last compliance visit, the Hospital Liaison Nurses had been certified by the Denton Regional Medical Center to have access to individuals' hospital records, both onsite and electronically. This significantly improved the ability for the medical providers, nursing staff, and other relevant Personal Support Team members to have ready access to individuals' immediate hospitalization records, as well as emergency room records and other medical records. The Monitoring Team interviewed the Hospital Liaison Nurses, listened to their reports at the Morning Meeting Rounds on 9/20/11 for individuals hospitalized (Individuals: #524, #42, #336, 228, #18, and #552), and reviewed documentation for individuals who were hospitalized at the time of the compliance review. This review demonstrated that the Hospital Liaison Nurses performed the following activities: Prior to the hospital visits reviewed medical	

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		information, lab work results, and vital signs. Made daily hospital rounds that included physical assessments, chart reviews, and interviews with nurses and physicians providing care to individuals. After the visit to the hospital, all medical information was scanned into the hospital reports folder and into each individual's folder, in order to make it available to medical providers, nursing staff, and other relevant PST members. The Hospital Liaison Nurses attended morning rounds and reported on hospitalized individuals. They maintained communication with the RN Case managers, Unit Directors, Qualified Mental Retardation Professional (QMRP), Wound care Nurse Occupational and/or Physical Therapist, and other PST members as necessary. The PST members were notified as soon as pending discharges were known in order to discuss any necessary training or equipment needed on discharge. In addition, the Hospital Liaison Nurses attended and participated in Physical and Nutritional Management Team (PNMPT), Personal Support Team (PST), Clinical Death Review Committee, and Critical Incident Team (CIT) meetings as needed for hospitalized individuals. By the PSTs having the Hospital Liaison Nurses' information readily available regarding hospitalized individuals' status, they should be able to identify when there are significant changes in status that would require revising their risk ratings. <u>Diabetic Educator Activities</u> At the time of the compliance review, the Facility had 50 diagnosed cases of diabetes. As was found at the last compliance review, the Diabetic Educator continued to consistently follow all individuals diagnosed with diabetes. Some individuals whose diabetic conditions were less well controlled required increased assessments/monitoring, and coordination of integrated services. A review of the Diabetic Nurses' documentation for Individuals #505, #11, #331, 89, #560, #517, #335, #331, and #19, demonstrated her efforts toward assisting these individuals in maintaining control and/or managing episodes of hyperglycemia and/or hypoglycemia. For individuals #505, #11, and #331 who had wide swings in blood sugar levels, daily Blood Sugar Logs were maintained that recorded the time and type of insulin administered and the resulting blood sugar levels. These logs provided the medical providers and endocrinologist with valuable information to assist with regulating individuals' insulin dosages and diabetic management. In addition, the Diabetic Educator continued to consistently perform the following activities: • Attended Morning Rounds. These reports become the focus for the day by identifying individuals who had experienced problems with elevated blood sugar levels, insulin administration, dietary intake, and potential education needs of the staff or individual. • Rounds to various apartments across campus were conducted daily to visit staff and individuals with diabetes to assess progress, as well as to review pertinent health information, develop trends, document findings in the Integrated Progress Notes, communicate, with the RN case managers, medical providers, dietitian, and/or other	

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		related PST members. • Maintained a log of visits that included the name of the individual, date of visit, reason for the visit, and intervention/plans. • Accompanied individuals to appointments with the Endocrinologist. Prepared an informational packet to take to the appointment that included recent lab results, radiology reports, consultation reports of recommended referral (vision, cardiac, and others as indicated), medication list, physician's annual summary, and spreadsheet of all blood glucose reports and insulin administration since the last appointment. • Color coded instruction sheets "Memory Joggers for Diabetic Care" were posted in all Home Shift Logs and Individual Notebooks which identify the individuals who reside in that home who are diagnosed with diabetes. The information sheets provide instructions for care consideration and management of diabetic emergencies. • Provided diabetic care and management training during New Employee Orientation (NEO). Through a review of the documentation it was apparent that the increased surveillance and coordination of services provided by the Diabetic Educator Nurse showed the effectiveness of the interventions set forth since the last compliance review. This was demonstrated by better diabetic control of individuals #11, #505, and, #331, whose incidents of hypoglycemia and hyperglycemia were less frequent, as were visits to the hospital and/or emergency room for diabetic emergencies. As a result of the increased education the nursing staff and direct care professionals were more aware of individuals' change in status when blood sugar levels were out of range and/or when presenting with signs and symptoms of hypoglycemia and hyperglycemia. Therefore, they responded timely to intervene and manage these conditions. Nevertheless, as reported in Provision L.1, there were examples in which supports and services for individuals with diabetes needed to be addressed in the PSP in a more integrated manner. The actions taken with the leadership of the Diabetic Educator Nurse were valuable; the Monitoring Team looks forward to seeing further progress. During the compliance visit, the Monitoring Team discovered that the nursing staff were not routinely calibrating the glucometer machines and were using the wrong testing solutions for some of the glucometer machines. This was called to the attention of the Diabetic Educator Nurse and the CNE. The Nursing Department immediately developed and implemented the Nursing Protocol: Glucometer Quality Control (QC), 9/20/2011. The Monitoring Team will follow up for compliance with this protocol at the next compliance visit. Refer to Section L for more information regarding medical management for diabetic care and management.	

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		Wound Care Nurse The Wound Care Nurse consistently followed, tracked, and reported skin integrity issues and decubitus ulcers. There was documented evidence in records of individuals with such conditions that the Wound Care Nurse collaborated with other relevant disciplines to provide integrated care. She also consulted with the Wound Physician and provided training on skin integrity care issues to the nursing and direct care professionals. At the time of the compliance review there were two individuals reported to have unresolved decubitus conditions. It was commendable that there were no more individuals found with decubitus ulcers than were identified, considering the Facility's large a population with many individuals being medically fragile. This was no doubt attributable to the competent skills and commitment of the Wound Care Nurse and her efforts to ensure integrated care. The Skin Committee was disbanded and skin integrity issues were folded into the PNMP Committee. This will further enhance integration of services. Availability of Pertinent Medical Records Since the last compliance review, the clinical records were better organized and more accessible. Often individuals' completed At Risk Screening Assessments and At Risk Action Plans were not found in their records, although the results of At Risk Screening Assessments and related action plans were often found incorporated into their PSP and/or PSPA. Infection Control It was positive to find since the last compliance review, that the Nursing Department had hired an experienced Infection Control Preventionist Nurse. She is a member of the Association for Professionals in Infection Control and Epidemiology (APIC) and the Texas Society for Infection Control and Prevention. The Facility had also contracted with an Infection Control Physician. A review of the Infection Control Preventionist Nurse's Duties and Responsibilities found that they were consistent with the standard requirements for long term care facilities. A review of documents and interview with the Infection Control Preventionist Nurse showed that significant improvements had been made and more were in process. The improvements showed promise in moving the Facility toward compliance with requirements for this provision. A review of the quarterly Infection Control Committee Report, 4/2011 through 6/2011, contained significant improvement in the quality of the reporting. The minutes included the following number and percentage per census of infectious and/or communicable diseases: • Soft and Soft Tissue Infection (SSTI) – 132 or 40% • Urinary Tract Infection (UTI) – 54 or 16%	

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		• Conjunctivitis – 36 or 11% • Respiratory – 34 or 10% • Non-Aspiration Pneumonia – 32 or 10% • Aspiration Pneumonia – 17 or 5% • Methicillin-resistant Staphylococcus Aureus (MRSA) – 12 or 4% • Clostridium Difficile (C-diff) – 5 or 2% • Pseudomonas – 7 or 2% (It was reported that most of these cases were hospital acquired and found in urine.) • Vancomycin-resistant Enterococcus (VRE) – 1 or 0% In addition to the above numbers and percentage per census for infectious and communicable diseases, it was positive to find that that incident rates for reportable infectious and/or communicable diseases were tracked and analyzed by the number of infections divided by census times 1000 (1000 patient bed days). This was in keeping with standard practices for calculating rates of infections. This will provide reliable data to identify infectious/communicable disease trends. Infection rates were provided for the first and second FY2011 quarters. There was no documentation found explaining how these data would be used or a threshold established to indicate at what point a trend would be identified. The Infection Control Preventionist should collaborate with Facility providers and the contract Infection Control Physician to establish a protocol for identifying and managing trends based on rates of infections. The Infection Control Preventionist had developed an Anitbiogram Policy, describing in detail how it was constructed and used. Each month she reviewed the names of antibiotics ordered by the physician for individuals who had cultures and sensitivities and crosschecked the information with the monthly Epidemiology Report. Using the Antibiogram, she analyzed the percentage of effectiveness of the antibiotics prescribed to treat infections, and the results were presented and discussed at the Pharmacy and Therapeutic Committee meetings. It was positive to find that the Infection Control Preventionist Nurse attended the 9/2/2011 Pharmacy and Therapeutic Committee meeting and provided the percentage of the antibiotics used to treat infections for the month of August. An example of the analysis revealed that eight infections (one wound and seven urinary tract infections) were due to the Escherichia coli (e-coli) organism. The percentage effectiveness of the antibiotic prescribed to treat those infections included: Levofloxacin - 25%; Amoxicillin – 38%; and Sulfamethoxazole – 75%. This information was important for providers to know to ensure that the most appropriate and effective antibiotics are prescribed to treat specific organisms for the Facility's population. In addition, this meets the Settlement Agreement and Health Care Guidelines requirement that the Infection Control Department and Pharmacy Department monitor antibiotic prescribing practices.	

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		In order to further assist the clinical staff to recognize, assess, and manage infectious and/or communicable disease processes, the Infection Control Preventionist Nurse had begun developing medical algorithms; to date they had been developed for MRSA and conjunctivitis. A formalized procedure was in place for checking the reliability of the infection control data. The Infection Control Preventionist Nurse provided follow-up consultation and training to unit nurses and direct care professionals on reported infections/communicable diseases to improve the quality of care and to control an/or prevent the spread of infections. The Monitoring Team validated this though document/record review and interview. The Infection Control Preventionist Nurse stated when there was a high incidence of a particular infection, she went to the home(s) and completed an assessment, developed a plan of action, and provided the necessary interventions. Then, the nursing staff and direct care professionals were provided training on the infectious disease process, prevention and control of the infection. Examples include: • There was documentation of the management of care provided for Individual #14, who had a diagnosis of scabies. In addition to the consultation provided for Individual #14's care, Scabies Control Measures were put into place. There was documented evidence of training and close collaboration with the providers, PST, and the Infection Control Physician. The scabies infection was followed-up through to resolution. • There was documentation that consultation was provided to the nursing staff regarding the management of care for Individual #526 and Individual #505, who were diagnosed with conjunctivitis. • There was documentation that consultation was provided to the nursing staff regarding the management of care for Individual #191, who was diagnosed with MRSA in the G-tube stoma. • There was documentation that the direct care professionals in home 504B were trained on the management of Impetigo. The Infection Control Preventionist Nurse conducts Aspiration Pneumonia Surveillance. Refer to Section O for information on aspiration pneumonias. As identified in previous compliance reviews, the Facility employees continued to be delinquent in tuberculosis screening. Aggressive efforts were underway to provide delinquent staff with opportunities to receive tuberculosis screening. On 9/6/2011 through 9/9/11, multiple clinics were held at different times for staff on the three shifts. As a result 137 of the 291 (47%) of the delinquent employees received screenings. There was an ongoing effort to ensure all delinquent employees received screening by	

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		encouraging Unit Directors and Building Coordinators to send their employees for screening. The Infection Control Preventionist Nurse manages the Influenza Program facility-wide and was in the process of coordinating the Flu Vaccine Clinic. The status of individuals' tuberculosis screenings and immunizations was not available for review. This will be followed up at the next compliance review. The Infection Control Preventionist Nurse needs to ensure the status of individuals' tuberculosis screenings and immunizations are tracked, as well as collaborating with providers to ensure they are up to date. Since the last compliance review, the Infection Control Preventionist Nurse had formalized a Surveillance Procedure that provided instructions for each surveillance item monitored, e.g., Environmental Surveillance, Handwashing, and Infection Control Rounds. Since 7/2011, the Infection Control Preventionist began conducting surveillance of infection control practices system wide and reported significant findings to appropriate committees, Incident Management Report Team (IMRT), Unit Directors, and Building Coordinators. With the exception of the handwashing data reported in the Infection Control Report, there were no other formalized reports regarding the monitoring activities. The Monitoring Team was provided copies of raw monitoring data for review. While it appeared on the surface that the monitoring activities were conducted and individual recommendations made for identified deficiencies. Because the data were not analyzed and trended, it was not possible for the Monitoring Team interpret the data to adequately evaluate the effectiveness of these monitoring activities. In order for the surveillance monitoring data to be useful facility-wide, for internal management purposes, and to demonstrate compliance with this provision, the Infection Control Preventionist Nurse should: analyze, trend, develop and implement corrective action plans for identified deficiencies, evaluate their effectiveness, and report findings in the Infection Control Committee Reports, as well as other required Facility reports. The Infection Control Preventionist had developed several new Infection Control Policies, Procedures, Processes, as well as revised others, using the revised State Infection Control Reference Guidelines. They included: • Infection Control Practices for an Influx of Infectious Individuals • Multi-Drug Resistance Organisms Policy (revised 8/15/2011) • Surveillance Policy, 8/15/2011 • Reporting Employee Absence Policy, 8/15/2011 • Management of Employees with Contagious or Infectious Diseases Policy, 8/15/2011 • Occupational Exposure to Tuberculosis Policy, 8/15/2011 • Employee Illness Log Procedure	

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		• Antibiogram Procedure • Hand Hygiene Policy (revised) The Infection Control Preventionist provided Infection Control training at New Employee Orientation (NEO) using the State's standardized training module. In addition, supplementary training material was added to the training on standard precautions and handwashing criteria based on the Centers for Disease Control (CDC) Guidelines with return demonstrations, as well as other relative topics. The CTD Due/Delinquent Training Report for Infection Control was not available for review. It was impressive to find the significant improvement made in the Infection Control Program since the hire of the experienced Infection Control Preventionist Nurse. Many of the improvements occurred in recent months and need time to mature in order to measure their effectiveness. In addition to maintaining the positive practices identified in the report, and in order to meet compliance with the requirement of this provision the Facility should consider making the following improvements to the Infection Control Program: • The Infection Control Preventionist should collaborate with Facility providers and the contract Infection Control Physician to establish a protocol for identifying and managing trends based on rates of infections. • The Infection Control Preventionist Nurse needs to ensure the status of individuals' tuberculosis screenings and immunizations are tracked, as well as collaborating with providers to ensure they are up to date. • In order for the surveillance monitoring data to be useful facility-wide, for internal management purposes, and to demonstrate compliance with this provision, the Infection Control Preventionist Nurse should: analyze, trend, develop and implement corrective action plans for identified deficiencies, evaluate their effectiveness, and report findings in the Infection Control Committee Reports, as well as other required Facility reports. <u>Mock Medical Emergency Drills and Emergency Response</u> It was positive to find that since the last compliance review, the Facility had made significant improvements to the Mock Medical Emergency Drills and Emergency Response system. The improvements were verified through interviews with Deb Salsman, Director of Incident and Risk Management, Chuck Brookins, Security Officer, Jeron Dotson, Incident Management Coordinator, 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), and documents requested off-site and on-site. The Monitoring Team also reviewed CMS 2567 Report, 6/7/2011, which found the Facility "failed to follow its policies and procedures	

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		by failure to ensure one individual was not neglected during and emergency situation where the individual was found unresponsive…" Numerous emergency response corrections were made in response to the CMS 2567 Report. The Monitoring Team's asked the emergency response staff if signs were posted throughout the Facility identifying the location of emergency equipment; staff related that signs were not posted. They agreed signs should be posted identifying the location of emergency equipment. Additionally, the need to record response time initially to and during the drill should be recorded on the Mock Medical Emergency Drill sheets. While it was not permissible to change items on the standardized drill sheets, the Facility should be able to add information they need on to the drill sheets. The Emergency Response improvements included the following activities: • Formalized a Drill Committee Policy and Procedure to include the following information: o Membership of the Committee included: ▪ Center Director ▪ Assistant Director of Programs ▪ Director of Quality Assurance ▪ Director of Risk/Incident Management ▪ CNE ▪ NOO ▪ Medical Director Safety Specialist ▪ QA Nurse o The Drill Committee will meet at least once a quarter. The Safety Specialist will complete and maintain minutes of all meetings. An electronic copy of the minutes will be distributed to all committee members. The completed minutes will be stored on the S:/drive in the Risk Management folder. • The Facility's need for additional emergency equipment and resources to ensure all areas had the necessary equipment and resources readily accessible to response to emergency situations was assessed. The needed emergency equipment was ordered. • The Safety and Security Services Operating Instructions were revised to include instructions for a back-up security vehicle fully equipped with emergency equipment and a back-up security team to respond to simultaneous emergencies. All Security Officers were trained on the expectations during an emergency, which included brining the emergency equipment bag to the scene and then escorting the Emergency Medical Services to the scene. • Developed different scenarios used during CPR Drills, e/g., placing manikins in different areas outside and inside the Facility. • Began monthly and cumulative Mock Medical Emergency Drill Compliance Trending.	

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		Monthly trend results were represented by line graphs. Trend data from 1/2011 through 8/2011 indicated compliance with staff's drill performance ranged from 100% to 96%. Trend data was provided to the Quality Assurance Department. • Reported results of the completed Mock Medical Emergency Drills, including any corrective action taken at the Incident Management Review Team Meetings, as well as at the Fire Drill Committee Meeting. With the implementation of the recent Drill Committee Policy and Procedure, the results and any plans of correction will be reviewed and discussed at committee meetings. • The Quality Assurance Nurse, who was also a Certified CPR Drill Instructor, continued to conduct and oversee the quality and effectiveness of the drills. • A scribe was assigned to document response time to and during the drills in order to improve the timeliness of response during the drills. • Notebooks and pens were placed in all emergency kits that the Security staff brings to the scene of an emergency so that the response time can be documented, particularly in the event of a code, to ensure that time sequences of response to the event are accurately documented. • Review of the Mock Medical Emergency Drill Schedule for the past six months indicated that drills were completed according to schedule. If not, there was documentation that the Security Officer responsible for overseeing the drills notified the responsible staff for conducting the delinquent drill and followed up to ensure that the drills were conducted. • Review of the completed Mock Medical Emergency Drill sheet for the past six months, indicated there was documented evidence on the drill sheets that when staff failed to perform correctly they were re-trained "on the spot." Those staff who failed to perform satisfactorily after "on the spot" re-training were sent back to Competency Training and Development for retraining on CPR. • Physicians were beginning to participate in the Mock Medical Emergency Drills. • A list was developed and distributed identifying the location of all emergency equipment throughout the Facility. • In addition to the current practice of nurses checking for the presence of Ambu-bags, the Respiratory Therapist was made responsible for checking all Ambu-bags for good working order quarterly. • According to the Facility's POI, Section M.2, the nursing staff had received in-service training, 7/13/2011, on Critical Incident Team (CIT) Policy updates and Med-06 Life Threatening Emergency updates. The Section M Presentation Book included signed In-service Training Sheets for these training items. However, the percentage of nurses trained were not summarized and included in the Presentation Book. Therefore, the Monitoring Team was unable to determine the status of compliance with the training provided.	

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		The Facility had received and apparently implemented the State's revised Emergency Response, Policy Number: 044.2, dated: 9/7/2011. There was no training documentation available to review to determine the status of staff's training on this revised policy. The revised policy provided significantly improved and comprehensive instructions for emergency response procedures, as well as improved standardized forms for Emergency Drill Checklist, Emergency Oxygen Tank and Suction Machine Checklist, AED (Automated External Defibrillator), Emergency Bag Check Off Sheet, and Emergency Equipment Walkthrough Checklist. This revised policy should further assist the Facility with improving their emergency response system. As a result of the revised Emergency Response Policy, in addition to scenarios placing the manikin in various locations inside and outside the Facility, other scenarios should be considered to include emergency situations listed in the policy. A review of the CTD Due/Delinquent Training List for CPR for Health Care Providers and CPR: Basic, found that no staff were delinquent in CPR for Health Care Providers training but found eight staff were delinquent in CPR Basic training. A review of all required Emergency Equipment Checklists found that Security Equipment Verification Checklists were consistently completed daily and on all shifts. While there was noted improvement by the nursing staff in checking emergency equipment daily and on all shifts, as was found at the last compliance review, the Control Drug Check Sheets and Emergency Checklists were not consistently completed daily and/or on all shifts. As mentioned above, the amount of improvement the Facility had made in their emergency response system was impressive. As a result of the numerous improvements, the Facility has moved close to compliance with this requirement of the provision. Many of the improvements occurred in recent months and need time to mature in order to measure their effectiveness. In addition to maintaining the positive practices identified in the report, and in order to meet compliance with the requirement of this provision the Facility should consider making the following improvements: • Post signs throughout the Facility identifying the location of emergency equipment. • Add response times, initially and during the drills, to the Mock Medical Emergency Drill form. • Ensure that all required staff remain current in CPR training. • Ensure that all required staff receives training on the revised Emergency Response Policy, 9/7/2011. • Ensure that when additional emergency response training is provided that the percentages of staff trained are tracked to ensure all required staff have completed the required training. The results of the trainings completed should be reported in	

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		the Drill Committee minutes and/or in other relevant reports. • Ensure that the nursing staff consistently checks all Controlled Drug Check Sheets and Emergency Equipment according to Facility policy. The Drill Committee should also review and analyze the emergency equipment to identify problems/trends resulting from incomplete checks of emergency equipment and develop CAPs when appropriate.	
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.	The Facility's POI stated they were not in compliance with this provision and the Monitoring Team concurs. According to the Facility's POI, since the last compliance review, the Nursing Department completed the following activities: Met RN Case Managers to discuss training for home staff regarding missed appointments, and responsibilities related to final/transfer assessments for individuals who moved to the community or who had expired. They were in-serviced on the importance of completing physical assessments timely and according to regulations. A workgroup met to discuss community placement and to develop a list of questions for the RN Case Managers to ask at the Provider Fair on 9/9/2011. They reported an overall compliance in Annual Nursing Assessments had increased from 87.7% in 3/2011 to 93.9% in 7/2011. As will be demonstrated in the report below, only marginal improvement was noted as a result of these activities. It was apparent through interviews, review of Section M Presentation Book, and review of individuals' records that the Nursing Department had put forth concerted effort with increased training of the RN Case Managers on completing the Comprehensive Nursing Assessments. With the exception of training reported by the Nurse Educators, the other training documentation that was supplied in the Presentation Book to validate training was copies of signed in-service sheets. Therefore, it was not possible for the Monitoring Team to discern if all required nurses received the specified training listed on the signed in-services sheets. Refer to Section M.4 for more information regarding training activities. Since the last compliance review, additional headings had been added to the overall nursing summary section. Additional headings included: Personal Focus Assessment, Review of Health Status from previous quarter/annuals, Health Risk Reviews, Self-Administration of Medications progress and recommendations, Nursing Problem/Diagnosis, Health Management Plans and progress, Recommendations, and Community Integration. Annual/Quarterly Comprehensive Nursing Assessments for 17 individuals who were identified by the Facility as being at risk for specific health indicators were reviewed for the following Individuals: #697, #580, 291, #19, #657, #438, #279, #478, #102, #11,	Noncompliance

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		#352, #642, #601, #537, #119, #776, and #3. On 9/21/2011, the Monitoring Team met with the CNE, NOO, RN Case Manager, and three groups of RN Case Managers to review their records for Individuals #697. #580, #291, #19, #657, #102, #438, #478, and 279. The focus of the review and discussion was on At Risk Screening Assessments, Risk Action Plans, PSPs/PSPAs, Annual and Quarterly Comprehensive Assessments, and Health Maintenance Plans (HMPs). The group stated they found the review beneficial and provided better insight into the requirements for compliance with these items. They were able to self-identify problematic trends that needed improvement. A RN Case Manager stated that the PSP Action Plans were not consistent with the nursing established nursing care plans. When asked by the Monitoring Team if the RN Case Managers reviewed the final PSPs to ensure that the nursing related action steps were correct and/or included all of needed nursing action steps, the RN Case Manger stated the PSPs were not reviewed. The nursing responsibility for completing the At Risk Screening Assessments was discussed. The need to exercise clinical judgment and critical thinking when assessing risk factors was emphasized, in addition to following the At Risk Guidelines. Interrelated risk factors should be considered when assigning levels of risk. The results of the nine records reviewed revealed the following findings: • Twenty-one of the 35 (60%) Annual/Quarterly Comprehensive Nursing Assessments reviewed were completed according to their PSP schedule. • Nine of the nine (100%) of the Annual/Quarterly Comprehensive Nursing Assessments included a BRADEN skin assessment. • Four of the nine (44%) of the Annual/Quarterly Comprehensive Nursing Assessments were completed according to the requirements. • Five of the nine (56%) nursing summaries adequately summarized each nursing problem/diagnosis to indicate individuals' status of progress related to their specific condition. • Four of the six (67%) records reviewed for the nursing problem/diagnosis lists that required HMPs included relevant risks and medical diagnoses.. Three records were not reviewed for this item because the nurses failed to turn over the review sheet and respond to the review questions. • Three of six (50%) indicated that HMPs were individualized to meet individual needs. Three records were not reviewed for this item because the nurses failed to turn over the review sheet and respond to the review questions. • Three of six (50%) of the nursing summaries included information indicating the effectiveness of the HMPs. Three records were not reviewed for this item because the nurses failed to turn over the review sheet and respond to the review questions. • Three of the six (50%) indicated that the effectiveness of the HMPs were included in the nursing summaries. Three records were not reviewed for this item because the	

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		nurses failed to turn over the review sheet and respond to the review questions. • Two of the six (33%) records reviewed included documentation on the HMPs and in the Integrated Progress Notes that the HMPs were established and the direct care professionals were trained on the HMPs. The RN Case Managers explained that the HMP training was signed on an in-service sheet that was placed in the individuals' notebooks in the homes. • Eight of the nine (89%) indicated that the QMRPs were sent copies of the completed Annual/Quarterly Comprehensive Nursing Assessments. • Nine of the nine (100%) were signed and dated by the RN Case Managers completing the Annual/Quarterly Nursing Assessments. The Monitoring Team's independent review of records for Individuals #11, #352, #642, #601, #537, #119, #776, and #3, found trends consistent with those identified above. Nineteen of the 28 (67%) Annual and Quarterly Comprehensive Nursing Assessments reviewed were completed according to the individuals' PSP schedule. Although the assessments were not completed on time, they were either found completed after the due date, or were in process. Some of the RN Case Managers indicated there was a misunderstanding as to when the assessments were due, and some of the due dates had been changed but the RN Case Managers had not changed their due dates. The Annual/Quarterly Comprehensive Nursing Assessments review contained significantly more data, including the new headings. However, they did not significantly improve the quality of the overall nursing summaries. The most improvement noted included the listing of individuals' risk factors in the nursing problem/diagnosis section with some degree of rationale. With rare exception, Health Maintenance Plans were developed for the identified risk factors, as well as other active medical and nursing problems/diagnoses identified. Although it was apparent from the increased amount of data included in the overall nursing summaries that efforts were made to improve the quality of the summaries, problematic concerns remained. The summaries more consistently addressed each problem/diagnosis identified, but the summaries failed to adequately reflect individuals' health status progress or lack of progress from quarter to quarter or annually, as well as the effectiveness of their Health Maintenance Plans. The summaries of the problems/diagnosis continued to contain lists of raw clinical data related to sequential events, such as hospital/emergency room or infirmary admissions, clinic visits, medication and treatments received, diagnostic and lab results, with no associated analysis of the data indicating if the health issues was getting better or worse. The summaries varied in format and content from one RN Case Manager to another. Thus, there was no continuity with the various formats used by the Nursing Department. Based on the findings of this review, and in past reviews, it was apparent the Nursing Department was consistently putting forth effort to improve the analysis and quality of	

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		the summaries in the Comprehensive Nursing Assessments. However, a continuing need was identified to help the RN Case Managers understand how to analyze, summarize and document clinical health data that will result in adequately and accurately summarizing the individuals' progress or lack of progress toward their established goals and objectives. An adequate and accurate analysis and summary of individuals' clinical health data is not only necessary for the RN Case Managers in appropriately planning individuals' care but it is also important for the PST to incorporate into individuals' PSP and/or PSPA. Some of the specific concerns identified in the review of the Annual/Quarterly Comprehensive Nursing Assessment included: • Individual #537 had active medical problems for obesity and chronic deep vein thrombosis of the right leg with edema, was on Coumadin therapy and was rated as medium risk for circulatory and high risk for weight. With these risk factors the PST should re-evaluate the circulatory rating of medium and consider changing to rating to high. Individual #537's past year's Annual and Quarterly Comprehensive Assessment documented he consistently refused to allow the RN Case Manager to complete a physical assessment or to take vital signs. A complete physical assessment is critical to accurately assess his health status, particularly as related to the cardiovascular/circulatory system. There was no indication found in the assessments that this was a significant problem, except to say he refused the assessments and that this was "normal for him." The routine refusal of individual #537 to not allow necessary assessment could be detrimental to the early identification and treatment for changes in health status. The RN Case Manager should refer Individual #537's refusal to allow the physical assessment to the PST, particularly the Behavior analyst, to consider remedies to resolve the problem. The Nursing Department should ensure the RN Case Managers notify the PST when in individuals refuse to allow physical assessment and/or vital signs after reasonable effort has been made to resolve the problem. On a positive note, the review of Individual #537's overall nursing summaries for the past year most adequately summarized his health status in terms of progress or lack of progress for each nursing problem/diagnosis for which there was a plan of care. The summaries did not contain a copious amount of raw data. • Individual #776 was in the hospital when the Quarterly Comprehensive Nursing Assessment was due on 5/13/2011. The assessment was started but was incomplete. The RN Case Manager noted on the assessment that it would be completed when the individual was discharged from the hospital. Individual #776 was discharged from with hospital on 5/19/2011 but the quarterly assessment was never completed. Individual #776 was rated at high risk for aspiration, respiratory	

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		compromise, constipation, osteoporosis, and infections. She was rated at medium risk for urinary tract infections, diabetes, gastrointestinal problems, and polypharmacy. After she was discharged from the hospital, the PST met on 5/23/2011, 6/6/2011, and 6/20/2011 and developed a Risk Action Plan due to respiratory and gastrointestinal problems (J-G-tube complications) that led to the hospitalization. Because of these risk ratings, compounded with the medical/heath issues, and development of a Risk Action Plan it was essential that the quarterly assessment be completed to identify health status changes and the need to implement new plans of care. In addition, according to the uncompleted assessment, 5/13/2011, Individual #776's current weight was 106.4 pounds. The weight of 120 pounds was recorded for 3/2011. This represented a significant unplanned weight loss of 13.6 pounds or 11.4%. Weight loss was not discussed in the Risk Action Plan meeting. This also demonstrated the need for the nursing assessment to have been completed upon return from the hospital. The Nursing Department reported that the three Nurse Educators, one Infirmary Triage Nurse, and one Nurse Manager had completed the State's mandated Physical Assessment Class that also included training on documentation. Thirty-six additional RNs were scheduled to take the Physical Assessment Class at the end of September. As the RNs complete this class, there should be improvement in the nurses' ability to analyze and summarize health data into a more concise and meaningful way to adequately and accurately represent individuals' health status. The progress made toward improving the analysis and summary of health data, as a result of the Physical Assessment Class, will be evaluated at the next compliance review. The Facility's POI stated that a workgroup met to discuss a community placement process. A list of questions was to be developed for the RN Case Managers to use when they met with the community providers. The CNE stated the RN Case Managers met with the community provider at the Provider Fair on 9/9/2011. She said they found this meeting informative and useful in planning for community placement. She further stated the State Nurse Workgroup was developing a community/transfer Discharge Nursing Assessment format. The Monitoring Team will follow-up on the progress made toward improving nursing's community discharge assessment at the next compliance review. Although improvements were made, this provision was not found in compliance. The Nursing Department needs to ensure that all RNs complete the Physical Assessment and Documentation Class as soon as possible. In order to meet compliance with this provision of the Settlement Agreement the positive practices identified in the report must be maintained and improvements made in other practices. The Nursing Department should make the following improvements: • Ensure that the RN Case Managers understand the timelines required by the PSP	

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		schedule for completing the Annual/Quarterly Nursing Assessment and that they maintain a current PSP schedule for completing the assessments. • Ensure that the RN Case Managers review individuals' finalized PSP and PSPA plans for accuracy and completeness related to the corresponding nursing's health care plans. • Ensure Comprehensive Nursing Assessments for individuals who are in the hospital when their Annual/Quarterly are due are completed upon discharge home. • Develop and implement a standardized format to use for completing the overall nursing summaries on the Comprehensive Nursing Assessments template.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	The Facility's POI stated they were not in compliance with this provision and the Monitoring Team concurs. According to the Facility's POI, since the last compliance review, the Nursing Department completed the following activities: Signature sheets were added to the health care plans to verify training was conducted with the direct service professionals on annual and revised plans. A process was begun for health care plans to be individualized based upon individuals' health care needs. Started competency-based training on care plans in the new nurse employee orientation. The workgroup of section leaders and RN Case Managers met to explore modification/development of HMPs to better address chronic health care needs, including: bowel management, management of side effects of psychotropic medication, hypertension, GERD, with and without hiatal hernia, urinary tract infections, diabetes and aging, as related to individuals with developmental disabilities The section leader completed one monitoring tool to ensure inter-rater reliability. As will be demonstrated in the report below, only marginal improvement was noted as a result of these activities. However, many of these activities were recently completed or were still in process and may not have had time to translate into practice. A review of 59 Health Maintenance Plans (HMPs) for eight individuals (Individuals: #11, #352, #642, #601, #537, #119, #776, and #3) found: • Fifty of the 59 (85%) had adequate baseline information. • Forty-five of the 59 (76%) had realistic and measurable goals established. • Seventeen of the 59 (29%) were individualized to some degree, but not totally. Some of the HMPs merely added the individuals' first name to the interventions/actions in the template from the Health Care Protocols for Developmental Disabilities Nurses with little modification. • Twenty-one of the 59 (36%) were reviewed but not consistently revised monthly. • One of the 59 (2%) contained the signature of the Home Leaders validating that the direct care professionals were trained on the HMP.	Noncompliance

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		As was found in this review, as well as in previous reviews, there had been only a slight improvement in the adequacy and quality of the HMPs. The Nursing Department continued to use the templates from the Health Care Protocols for Developmental Disability Nurses, resulting in plans that were primarily generic in nature and did not adequately meet individuals' unique needs for care. These protocols should only be used as a reference guide in developing health care plans. They should not limit the RN Case Managers ability to use their clinical judgment in developing a health care plan to meet the individuals' unique needs. After review of the HMPs, the Monitoring Team doubted that the RN Case Managers actually reviewed the appropriateness of some of the interventions/actions contained in the protocol templates as they developed HMPs to address specific problems. It was a concern that these protocols may function as deterrent to RN Case Managers in using their clinical judgment and critical thinking skills by solely relying on the protocols to develop HMPs. The effectiveness of the Health Care Protocols for Developmental Disability Nurses to develop individualized care plans should be further explored by the Nursing Administration and Management staff and/or the SSLC Nurse Workgroup. While there was some improvement found in the HMPs since the last compliance visit, in general they continued to lack adequate individualization to meet individuals' needs. The baseline data contained on the HMPs typically described the problems leading to the need for the plan of care and their health status. However, the goals and objectives established for the HMPs were not consistently clinically appropriate, realistic, and measurable in relation to the identified health problems. The HMPs included interventions/actions to address the immediate problem but rarely contain proactive interventions directed at preventing or minimizing the specific health risks. The HMPs did not contained adequate instructions to specify to the nursing staff the frequency interventions/actions were to be carried out, by whom, where, and when to document interventions/actions that were taken. There was documentation found on the HMPs that the RN Case Managers were beginning to review/revise them monthly. It was rare to find that HMPs were revised, although the individuals may have continued to have reoccurrence of the problems the plans were designed to resolve or minimize, e.g., episodes of emesis, urinary tract infections, skin integrity issues, and constipation. The effectiveness of the plans was not addressed in individuals' Annual/Quarterly Comprehensive Nursing Assessment. It is essential that the RN Case Managers continuously evaluate the effectiveness of the HMPs, particularly when individuals' problems are not resolving or minimizing. When the HMPs are not found effective they need to be revised and re-evaluated. The effectiveness of the HMPs need be documented in individuals' records and summarized in their Annual/Quarterly Comprehensive Nursing Assessments. The health care plans were not integrated with other disciplines, with exception of the	

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		instructions provided to direct care professionals. Sections F and G of the Settlement Agreement require collaboration with other disciplines regarding care plans so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in to all HMPs to adequately meet the total health care needs of individuals. It is essential that the RN Case Managers collaborate with other relevant disciplines when developing heath care plans that would require their expertise to meet the total needs of individuals. Some of the specific concerns identified in review of the HMPs included: • HMPs for Individuals # 11 and #642 included a confusing statement in their in-service training instructions for the direct care professionals. The instructions stated, "Staff will protect hands with gloves." In the context of the HMP, the Monitoring Team inferred this to mean the individuals would wear gloves to prevent scratching or minimize skin abrasions, which could be defined as restraint. However, following the compliance visit, the Facility informed the Monitoring Team that the instruction meant that staff should wear gloves to avoid cross-contamination. The Facility should revise this instruction and take care to ensure that instructions are clear in order to avoid inadvertent errors by staff in providing care and supports. • Individual #642 had a HMP for Alteration in Skin Integrity Related to Superficial Scratches/Abrasions and Skin Irritation. The goal statement was inadequate. The goal stated, "[Individual #642] will reduce the incidence of skin abrasions to five or less in the next the next year." The goal should be to prevent or minimize the incidents of skin abrasions in the next year; if a goal must be set, it should be to have no abrasions. Individual #642 also had a HMP for Chronic Occlusive Arterial Disease of Lower Extremities (Peripheral Vascular Thrombosis). The nursing intervention action plan, number 7, stated, "Advise individual to build exercise tolerance by increasing walking distance each day; increase distance to 1-2 miles as order by PCP." This action did not appear realistic for Individual #642 due to his respiratory compromise and the need to use a wheelchair for long distances, as defined by his PNMP. This goal should be revised to more appropriate actions to meet his needs and done in collaboration with the PNMT. • Individual #601 had a HMP for Urinary Tract Infection. The goal was inadequate. The goal stated, "[Individual #601] will have no more than one urinary tract infection per quarter in the next 12 months." Individual #601 was reported to have four urinary infections in the past year. This goal would not show efforts toward reducing or preventing the occurrence of urinary tract infections. For an individual to have any urinary tract infection is not acceptable. Therefore, every effort should	

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		be made by the nurses and other relevant PST members to prevent or eliminate the occurrence. The goal should be revised to prevent or eliminate the occurrence of urinary tract infections in the next 12 months. Individual # 601 also had a HMP for Hay Fever. The goal statement was inadequate. The goal stated, "[Individual #601] to continue on current medication regimen and have a reduced number of emesis related to drainage/coughing." To have emesis is not a normal occurrence because of the serious risk for aspiration. Therefore, the goal statement should be revised to prevent the occurrence of emesis. The goal statement should be revised. • Individual #776 had a HMP for Gastro-esophageal Reflux Disease (GERD) with Hiatal Hernia. The goal statement was inadequate. The goal stated, "[Individual #776] will reduce emesis in half this next year." To have emesis is not a normal occurrence because of the serious risk for aspiration. Therefore, the goal statement should be revised to prevent the occurrence of emesis. • Individual #119 had a HMP for Psychotropic Medication Side Effects. While it was positive to find HMPs were being developed for psychotropic medications the plan was generic and did not address specific medication side effects that might occur specific to Zyprexa, e.g., increased appetite with unplanned weight gain and diabetes (hypoglycemia), or toxicity related to Valproic Acid. Individual #119 had a HMP for PICA. The goal was inadequate. The goal stated, "[Individual #119] will have no negative outcomes from swallowing foreign objects." This goal statement makes it appear that it is acceptable to swallow foreign objects as long as there were no negative outcomes. It is not acceptable for Individual #119 to swallow foreign objects. This goal statement needs to be revised to more appropriately address the prevention of PICA. Individual #119 had a HMP for GERD. The goal was inadequate. The goal stated, "[Individual #119] will continue with present bolus feedings with care not to overfill the stomach in too short a time, with less than five emesis in next year." To have emesis is not a normal occurrence because of the serious risk for aspiration. Therefore, the goal statement should be revised to prevent the occurrence of emesis. The CNE explained and demonstrated Red Notebooks the Nursing Department was in the process of completing for placement in the home. The notebooks would contain the care plan instructions for the direct care professionals to follow and refer to for each individual's HMPs and ACPs, medication profiles prepared by the Pharmacy, as well as other relevant health information. The Monitoring Team cautioned the nursing staff to ensure that the medication profiles were written in language that the direct care professionals could understand and follow. The utilization and effectiveness of the Red Notebook will be reviewed at the next compliance visit.	

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<tr><td></td><td></td><td>Although improvements were made, this provision was not found in compliance. In order to meet compliance with this provision of the Settlement Agreement the positive practices identified in the report must be maintained and improvements made in other practices. The Nursing Department should make the following improvements:
• Ensure that HMPs are integrated with other relevant disciplines to meet the individuals' total health care needs.
• Ensure that HMPs have clinically appropriate goals/objectives that are realistic and measurable in relation to the identified health problems.
• Ensure that HMPs are individualized to meet individuals' unique health care needs.
• Ensure that the HMPs include proactive interventions that are directed at preventing or minimizing the specific health risks. The interventions need to provide specific instructions for how frequently they are carried out, by whom, and where to document nursing actions.
• Ensure the RN Case Managers continuously evaluate the effectiveness of the HMPs, particularly when individuals' problems are not resolving or minimizing. When the HMPs are not found effective they need to be revised and re-evaluated. The effectiveness of the HMPs need be documented in individuals' records and summarized in their Annual/Quarterly Comprehensive Nursing Assessments.</td><td></td></tr>
<tr><td>M4</td><td>Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.</td><td>The Facility's POI stated they were not in compliance with this provision and the Monitoring Team concurs.

The Facility's POI reported a list of numerous trainings that the nursing staff had received since the last compliance review. Five RNs had received the mandated Physical Assessment Class, which included the three Nurse Educators, the Infirmary Triage Nurse, and the 10-6 shift Nurse Manager. Thirty-six additional RNs were schedule to attend the Physical Assessment Class 9/27/2011 through 9/30/2011. The direct care professionals were receiving training on Clinical Indicators.

The Nursing Department had adopted and implemented all of the core State nursing policies, procedures, protocol, and processes developed to date by the State Nursing Workgroup. The Nurse Educators continued to maintain a database for tracking training on Nursing Standardized Procedures – Protocols-Guidelines. The list below includes the status of training completed.

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>Seizure Management/Vagal Nerve Stimulator Protocol</td><td>99%</td><td>10/20/2011</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

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Hospitalization, Transfers and Discharges Protocol	98%	10/20/2011
Neurological Assessment Procedure	100%	10/20/2011
Post Anesthesia Care/REACT/Pre and Post Sedation Monitoring Nursing Protocol	97%	10/20/2011
Nursing Documentation Guidelines	99%	10/20/2011
Care Plan Development Procedure	97%	10/20/2011
Management of Acute Illness and Injury Procedure	99%	10/20/2011
Medication Administration Guidelines	99%	10/20/2011
Weight Management Procedure	100%	10/20/2011

It was commendable that the Nursing Department had achieved 97% to 100% compliance with the required training on the core nursing procedures, protocols, and guidelines. The effectiveness of the training on the above procedures, protocol, and guidelines are evaluated by the Monitoring Team in Section M.1, M2, M.3, M.5., and M.6.

A review of the Facility's POI and Section M Presentation Book indicated that the Nursing Department had provided training on numerous other nursing procedures, protocol, and guidelines. The information contained raw training data comprised of signed in-service sheets that were not analyzed to identify the percentages of nurses trained. Therefore, it was not possible for the Monitoring Team to discern the degree of compliance with those training topics. Training topics included but were not limited to the following topics:

- Preventing Aspiration Pneumonia – Memory Jogger
- Vomiting (Emesis) – Memory Jogger
- Sepsis
- Nursing Physical Assessment
- MOSES and DISCUS
- Process on Implementing Health Care Protocols
- Nursing's Responsibilities related Restraints
- Life Threatening Emergency Situation Med 06 Policy
- Quarterlies/Physical Assessments
- Comprehensive Nursing Assessment
- Nurse Educator Training (included Nurse Educators from other SSLCS taught by State Office Nursing Coordinator and Nursing Consultants)
    - Critical Thinking
    - Effective Communication
    - Principle of Adult Learning
    - Dysphagia
    - Respiratory In-Service

Although the signed In-service Sheets were turned in to Human Resource Development, the Nursing Department should maintain a tracking system for all nursing trainings

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		provided that are not tracked by the Nurse Educators. It is essential that the Nursing Department for internal management purposes track all required nursing training to ensure that all nurses receive training, identify nurses who are delinquent in training, and project a completion date for the training. Further, all training completed and tracked by Nursing Administration/Management should be centrally maintained in the Nursing Education Department for internal management purposes. Since the last compliance review the Nursing Department had refined and strengthened their Nursing Education. The Nurse Educators had implemented the Nurse Educator's Handbook and had begun using it for New Nurse Employee Orientation. The Nurse Educators Handbook contained competency-based material, in accordance with the Nursing Competency Based Training Curriculum Procedure. The nursing orientation process had been extended to six weeks and included a Preceptor Program to mentor the new nurses during the orientation period. The Nurse Educators had adopted and implemented the State's approved Preceptor Program Curriculum to training the nurses who were serving as preceptors to the nurses in orientation. In addition, a Nursing Orientation Survey was developed for the nurses to complete at least three months after orientation. This was initiated to evaluate their orientation experience and to assist with retention. The improvement made to the orientation process was a positive step forward in enhancing the new nurses' knowledge and skills in Developmental Disability Nursing, as well as assisting with retention. The routine Nursing Competency Testing process had changed from the Health Fair approach to a monthly competency check completed by the Nurse Educators. Each month the Nurse Educators scheduled a specific area of nursing practice to check for competency. The competency checks were completed according to instructions contained in the Nurse Educator's Handbook. This was a much improved approach to checking nurses' competency as compared to the previous approach in which nurses checked each other off. Since the last compliance visit, the Nursing Department had obtained a teaching manikin and breast module to use in teaching physical assessment. It was positive to find that the Nurse Educators had begun training on the State's mandated Clinical Indicators of Health Status Change Class at New Employee Orientation and were also providing the training to incumbent staff. It was projected that approximately 500 staff would need the training. They projected all incumbent staff would be trained by 12/2011. The objectives of the Class were to train support staff how to identify common clinical indicators (signs and symptoms), and respond and report changes in individuals' health status. It is essential that front line staff are adequately trained to recognize, respond, and report clinical indicators, since they are usually first to	

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		notice changes in individuals' health status. Although there had been continued improvements made, this provision was not found in compliance, but was close to reaching compliance. In order to meet compliance with this provision of the Settlement Agreement, the positive practices indentified in the report must be maintained and improvements made in other practices. The Nursing Department should make the following improvements: • Ensure that all required nurses receive training on existing and any newly developed and implemented nursing policies, and procedures, protocols, and processes. • Track all nursing training provided for internal management purposes, as well as to demonstrate compliance with this provision of the Settlement Agreement. Further, all training completed and tracked by Nursing Administration/Management should be centrally maintained in the Nursing Education Department.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	The Facility's POI stated they were not in compliance with this provision and the Monitoring Team concurs. Since the last review, the Facility continued to report in the POI that all required staff had been trained on the At Risk Individual Policy. Individuals' level of risk were continuing to be assessed using the Risk Guidelines, which contained criteria to serve as a guide to assist the PSTs in determining appropriate risk levels for designated risk categories. The review of risk and the assignment of risk levels occurred during the PST meetings. The RN Case Managers, in conjunction with the physicians, continued to be responsible for assessing risk factors in the following categories: • Aspiration • Respiratory Compromise • Cardiac Disease • Circulatory • Constipation/Bowel Obstruction • Diabetes • Gastrointestinal (GI) Problems • Osteoporosis • Seizures • Infections • Fractures • Fluid Imbalance • Hypothermia • Urinary Tract Infections	Noncompliance

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		To assess and provide technical assistance for the Facility's risk screening process the Monitoring Team observed two individuals' (Individuals #102 and #306) special risk meetings held to review their risk level while on site. Overall, the Team Members observed improvement since the last review. The PSTs were reminded that the Risk Guidelines were just guidelines and that other interrelated risk categories should also be considered to ensure that risk ratings reflect an accurate assessment of individuals' risks. The PST was beginning to engage in more clinical discussions using supporting clinical data, and exercising critical thinking than had been observed at past risk meetings. It was positive that the individuals' entire teams were present and participated in the meetings. Having the entire team present and actively participating is essential a to accurately identifying individuals' risk factors, assigning risk levels, and in developing appropriate and integrated Risk Action Plans for each identified risk factor with a score of high or medium. The Monitoring Team reviewed six individuals' (#478, #279, #19, #291, #697, and #580) most recent PST and PSPA meeting minutes, Risk Levels, and Risk Actions Plans. The review found that none (0%) of the records reviewed met compliance with all of the At Risk Individual and/or PSP Policies' criteria. Refer to Provision I.1 for more information regarding the Monitoring Team's observations and findings. It was apparent from interviews with the RN Case Managers, review of the individuals' Comprehensive Nursing Assessments used for the At Risk Screening Assessments, and observations at the Monitoring Teams' meetings that the PST members, particularly the clinical team members, deferred questions regarding clinical information, e.g., time and dates of health events, to the RN Case Managers. The PST members should have knowledge about issues or looked up information they were concerned about prior to the meeting. It is essential that each discipline responsible for their respective risk categories thoroughly complete an assessment of individuals' mental and medical health, as well as behavior status though collaboration with other relevant disciplines, including interviews with the individuals' direct care professionals, and thoroughly review clinical records prior to completing their portion of the risk assessment to bring to the PST meetings so that risk factors are accurately identified. Since the RN Case Managers typically take the lead on completing the medical/health related risk categories, it is essential that they corroborate their risk assessment findings with individuals' physicians prior to the PST meetings to ensure that all medical/health related risk factors are identified; and that the risk levels are accurately scored. Establishing a competent and reliable At-Risk system is essential in ensuring that those individuals who warrant the most clinical intensity are appropriately identified and provided appropriate care related to identified risk factor levels. Refer to Sections M.2 and M.3 for additional	

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		information related to nursing assessments of risks and health care plans. In order for the Nursing Department to meet compliance with this provision, The Nursing Department should ensure that the RN Case Managers, and other relevant nursing staff consistently meet all criteria contained in the At Individual Risk Policy and associated documents.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The Facility's POI stated they were not in compliance with this provision and the Monitoring Team concurs. According to the Facility's POI, the Quality Assurance Department monitored each nurse who administers medication on a quarterly basis. In 9/2011, the Unit Nurse Managers will complete monthly Medication Administration Observations. The Quality Assurance Department's Medication Administration Observations Reports were reviewed for the past six months. All results from the Medication Administration Observation monitoring tools and the Quality Assurance spreadsheet were sent to the unit RN managers and nursing administration for review and corrective action, as applicable. The Medication Administration Observation data were reported monthly by units/Infirmary as well as facility-wide. The Monitoring Team reviewed Quality Assurance data for the Medication Administration Observations, 3/2011 through 7/2011. These data showed improvement from the last compliance review. The reports provided the following percentages for monthly compliance with the monitoring tools: • March – 98% • April – 98% • May – 97% • June – 97% • July – 96% In addition to monthly percentage, the Facility data reports included the following information: Number of nurses observed, identified trends for items on the monitoring tools falling below 95%, and comparison of trends of current month to the previous month in terms of improvement or regression. Facility-wide trends of items on the monitoring tools falling below 95% compliance included: • Failure to clean pill crushers per Medication Administration Policy. • Failure to have start/stop dates documented on the Medication Administration Records. • Failure to secure the medication storage area when not in use. • Failure to secure medications during administration. • Failure to have instruction to crush medication on the Medication Administration Record.	Noncompliance

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		• Failure to provide individuals with privacy during medication administration. • Failure to count control drugs prior to and after removal from containers. • Failure to discard contaminated medications according to state/facility policy. • Failure to only pull medications for current medication passes. • Failure to clean spillage from bottles of liquid medication. • Failure to document medications as they were administered. • Failure to properly store internal from external medications on the med carts. • Failure to flush gastric tube according to physician orders. • Failed to pour liquid medications just prior to administration. The Quality Assurance Medication Administration Observation data was sent to the unit RN managers and nursing administration for review and disposition. However, the Monitoring Team was not provided with documentation specifically related to nursing practices as to whether corrective actions were taken as a result of the identified trend data and the effectiveness of the corrective actions, if corrective actions were taken. The Nursing Department should analyze and trend Medication Administration Observation data for internal management purposes relating to individual nurses' performance, as well as for specific unit, and facility-wide performance. This information should be included in the Facility's POI and the Presentation Books to demonstrate efforts toward compliance with this provision of the Settlement Agreement. The Medication Variance Committee minutes did discuss some systemic issues that related to some of the trend data, which included: The creation of two closets converted into medication rooms in Building 528 to provide individuals with privacy during medication administration. The need for medication start/stop dates printed on the Medication Administration Records to prevent medication errors. The interim Medication Administration Records were not supported by the Mediware, the WORx system. Medication Administration Record labels were recommended to decrease transcription errors. The labels will be piloted beginning 10/1/2011. The Monitoring Team will follow-up on the effectiveness of the use of labels to reduce medication errors at the next compliance visit. The Facility did not have an inter-rater reliability system to monitor the Medication Administration Observations. Since the Unit Nurse Managers were beginning to conduct the Medication Administration Observation, the Nursing Department in collaboration with the Quality Assurance Department should establish an inter-rater reliability system to ensure the accuracy of the medication administration observation data. The Monitoring Team conducted medication administration observations at the 4:00 pm med pass in Building 528 for A, B, C, and D Apartments. It was positive to find since the	

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		last compliance visit, this building had created two med rooms from closets. Dutch doors enclosed the room. During medication administration the nurse passed medications through the Dutch doors. Privacy screens were used to surround individuals when they received medication. It was also positive to find that the direct care professionals assisted the nurse by bring one individual at a time to the door to receive medication. This created a calm environment and avoided distractions for the nurse while administering medications. This should aid in preventing medication errors caused by distraction of the nurse. All of the individuals received medications orally. The two nurses observed correctly identified the individuals, called them by name, and told them what medications they were receiving and their purpose. The nurses followed correct medication administration practices. The med rooms and carts were clean and waste products properly disposed. The Facility's POI stated that on 3/1/2011 Physical and Nutritional Management Plans would be updated to include medication administration instructions. This did not comport with the records reviewed during the medication administration observations. PNMPs were present in the Medication Administration Records. Individuals #580, #217, and #349 did not have instructions for medication administration. All should have had special instructions for medication administration. The Nursing Department should collaborate with the Physical and Nutritional Management Team to ensure that the PNMPs include medication administration instructions for individuals who are at risk for choking and/or aspiration, have altered diet texture/consistency, and special instructions for dining, positioning, eating utensils/equipment. It was positive to find that the nursing staff were no longer using disposable plastic spoons to administer medication. Maroon spoons were used for individuals who required spoons for medication administration. The Medication Administration Records were reviewed for Individuals #580, #217, and #349. The nurses' signature sheets did not contain the signatures and initials for all for the nurses names printed on the sheets. The Nursing Department should monitor the Medication Administration Nurses' Signature Sheets to ensure that all nurses listed have signatures and titles documented. If there are nurses' names listed who are not working, they should be removed. A review of the Self-Administration of Medication (SAM) Records did not contain individuals' specific program objectives and the frequency in which they were to be carried out, although the nurses were routinely checking off the data sheets on the 6-2 and 2-10 shifts as if the objectives had been met. This was discussed with the CNE who acknowledged that the SAMs data sheets were inadequate and they were in the process	

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		of revising the SAMs system. The Control Drug Logs were checked and found to have two nurses' signatures for the 6-2 and 2-10 shifts. There were no signatures for the 10-6 shifts. The CNE explained that there were not signatures because the building did not have a 10-6 shift nurse nor were any of the individuals receiving control drugs during that shift. Although the building did not have a nurse on the 10-6 shift, the med carts contained controlled drugs. The purpose of checking control drugs by on coming and off going nurses each shift is to ensure the security of the control drugs. The Nursing Department should review this practice with the Pharmacy Department to ensure this is acceptable practice. According to the Facility's POI on 6/1/2011, nursing began including the date and time corrective actions were taken on medication errors. Two Medication Error reports were provided for validation in the Presentation Book. While it was positive to find this improvement had been made since it was a problem found at the last compliance review. A review of the Medication Error Reports validated that the nurses had dated and timed the corrective action on the records. However, there were other problems found with the reports which included: • The Medication Error Report, 8/20/2011, reported that Individual #755 received extra doses of carbamazepine (seizure medication) at 0800 and 1200. This was two separate medication errors and should have been reported on two separate reports. When more than one medication error is reported on the same report it skews the error data and causes inaccurate reporting of errors. Further, this error was not discovered and the physician notified until 8/24/2011 at 1400. The physician did not give any orders. This was a significant delay in discovering and reporting the error to the physician. The extra doses of carbamazepine given at 0800 and again at 1200 had the potential to cause toxicity. The physician should have been notified immediately, and Individual #755 monitored for toxicity and/or other untoward reactions. The nurse who committed the medication errors was not given corrective action until 8/30/2011. This should have been done sooner had the error been discovered timely to prevent further errors because she did not read the Medication Administration Record correctly. • The Medication Error Report, 8/29/2011, reported that Individual #580 missed the 1700 dose of Vimpat (seizure medications). The error was discovered on 8/30/2011. The physician was notified on 8/25/2011 at 1045. This was obviously an error in dating because the error occurred on 8/29/2011. Although the notification of the physician was four days delayed, an order was given to monitor for increased seizure activity. This error was rated as a Category C, e.g., an error occurred that reached the consumer but did not cause the individual harm. Since the physician order intervention to monitor Individual #580 for increased seizure	

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		activity it should have been a Category D, e.g., the error occurred that reached the individual and required monitoring to confirm that it resulted in no harm and/or required intervention to preclude harm. The Monitoring Team's review of the Facility's 10 most recent Medication Error Reports submitted through the document request revealed the following findings: • Seven of the 10 (70%) medication errors were discovered and reported within approximately 24 hours of discovery. Two of the 10 (20%) medication errors were discovered and reported four days after the error occurred. One of the 10 (10%) medication errors was discovered and reported 6 days after the error occurred. This represented a significant delay in discovering and reporting the medication errors. • Although ten of ten (100%) medication errors were reported to the physician upon discovery, the delay in reporting errors to the physicians had the potential to have a negative impact on the individuals because it would have been too late to accurately assess individuals for any change in status resulting from the errors and to provide prompt medical intervention should individuals have had a change in status. This is particularly important when individuals miss critical medications, such as seizure, psychotropic, diabetic, and cardiac medications, to mention only a few. • Ten of the 10 (100%) medication errors contained documentation of corrective action taken for the nurse committing the error by the responsible supervising RN. However, three of the 10 (30%) did not have corrective action taken until 17 days after the errors occurred. One of the ten (10%) did not have corrective action taken until 12 days after the error occurred. One of the ten (10%) did not have not have corrective action taken until 10 days after the error occurred. One of the ten (10%) did not have not have corrective action taken until seven days after the error occurred. Two of the ten (20%) did not have not have corrective action taken until five days after the errors occurred. One of the ten (10%) did not have not have corrective action taken until four days after the error occurred. One of the ten (10%) did not have not have corrective action taken until two days after the error occurred. This represented a significant delay in corrective action. It is essential that prompt corrective actions are taken with nurses committing the errors to preventing the occurrence of future medication errors. • One of the 10 (10%) Medication Error Reports listed two medication errors on the same report, e.g., on 8/10/11 Individual #498 received improper does/quantity of lamotrigine (seizure medication), two tablets were ordered but only one tablet was at administered at 0700 and 1200. The medication error was not discovered and reported to the physician until 8/11/2011 at 0930. However, the physician did not provide new orders. The failure of Individual #498 to receive the correct dose of lamotrigine had the potential to cause break-through seizures and should have received closing monitoring after receiving the incomplete dose of medication. This	

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		represented two separate medication errors and two separate Medication Error Reports should have been completed. There was documentation that the corrective action was taken with the nurse. The responsible supervising RN failed to recognize that these were two separate errors and to correct the reporting. • Ten of the ten (100%) medication errors were Category C, e.g., errors that reached the individual but did not cause harm. However, one of the errors was reported as a Category C that should have been a Category D, e.g., the error occurred that reached the individual and required monitoring to confirm that it resulted in no harm and/or required intervention to preclude harm. Individual #409's lamotrigine (seizure medication) was omitted on 8/5/2011 at 1200. The error was discovered at 1900 and the physician was notified, who ordered, "Give the evening dose and give the missed dose at 2400." Because of the physician ordered to alter the time medication was to be given, this error should have been a Category D because the error required additional intervention. • Two of the 10 (20%) Medication Error Reports did not have the location of the error correctly identified, e.g., 5B and 5C. Since there are numerous buildings that have 5 Bs and Cs, proper identification of the location where the error occurred is essential for nursing management to locate, follow-up on, and to correctly enter the Medication Error Report into the database. Since the last compliance review the Facility had continued to report medication errors into a Medication Error Database using a root cause analysis approach. The database analyzed and trended data by month, unit/Infirmary, facility, shift, type of error, Category Index, nurses committing the error, individual for which the error was committed, and contributing factors. The data were represented by bar graphs including the number of errors represented, and had a color-coded legend explaining the graphs. This data provided the Facility with detailed medication error information from which to make decisions for corrective action to reduce the incidents of errors. The Monitoring Team was provided with medication error data from 2/3/2011 through 8/31/2011. The data were not summarized in a narrative that would assist the reader in interpreting the data. Through a review of the data, the Monitoring Team was able to identify the overall monthly number of nursing medication errors for the past six months, as listed below: • April – 45 • May – 32 • June – 28 • July 44 • August – 17 (This may be an artifact because it may not contain a full month's data.) The Nursing Department in collaboration with the Quality Assurance Department should develop a narrative explanation for the medication error/variance data, to include improvement and regression data similar to the other Quality Assurance/Quality	

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		Improvement data reports for other monitoring tools. The Facility had recently changed the Medication Error Committee to a Medication Variance Committee, in order to include a broad array of medication variances, in addition to medication errors/variances committed by all disciplines responsible for medication practices. The core membership for this committee included: Pharmacy Director, Medical Director, CNE, Director of Residential Services, Psychological Services Representative, and Director of Quality Assurance. A review of the Medication Variance Committee meeting minutes for 9/2/2011 and 9/20/11, and the attendance of the Monitoring Team, demonstrated a good structure consisting of the discussion, actions/follow-up, staff assigned, due data, and due for what and to whom. The Medication Variance Committee and Monitoring Team's observation at the 9/20/2011 meeting, demonstrated that the committee reported, discussed, and problem solved a variety of discipline specific medication practice issues. Example: The CNE provided a graph and discussion of nursing medication errors/variances from 9/2010 through 8/2011 that showed the most common type of errors/variances were due to omissions, which accounted for 257 of the 446 errors or 57% of all errors. The most common reason cited for these errors was distractions, accounting for 217 of the errors. The use of inexperienced and/or agency staff was cited for 87 of the errors. Unfortunately, the only action planned for the omission errors was for the CNE and RN Case Manager to monitor data for improvements in omissions. There were no actions described as to how the monitoring would be accomplished and how the monitoring data would be used to reduce the incidents of omission errors. As the committee matures it has the potential to improve tracking, trending, and development of substantial corrective action plans for all medication variances. At the next compliance review the Monitoring Team will evaluate the effectiveness of the Medication Variance Committee. According the Facility's POI, on 6/2/2011, the Pharmacy and Therapeutics Committee began summarizing medication errors in the meetings. This did not comport with the Monitoring Team's review of the Pharmacy and Therapeutic Committee meeting minutes. The review of the Pharmacy and Therapeutics Committee meeting minutes, 6/28/2011, 9/2/2011, and 9/20/2011, contained limited summaries of the medication error/variance data related to nursing. The 6/28/2011 Pharmacy and Therapeutic Committee meeting minutes indicated that the CNE did not have copies of the quarterly medication errors to distribute, but reviewed (verbally) the nursing data, broken down by unit, shift, and category. The actual number of quarterly errors/variances was not recorded in the minutes. Except for the discussion regarding the conversion of closets in two homes for medication rooms to provide less distraction during med passes, there were no other problem-solving discussions regarding medication errors/variances. The	

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		Pharmacy and Therapeutics Committee, 7/26/2011, meeting minutes did not discuss nursing medication errors/variances. The Monitoring Team attended the Pharmacy and Therapeutics Committee meeting, 9/21/2011, where the CNE presented the same nursing medication error/variance data reported at the Medication Variance Committee meeting on 9/20/2011. The Nursing Department should ensure that number and description of medication errors/variances; and the disposition of discussion and plans of corrective action, as well as the effectiveness of such actions are reported at the Pharmacy and Therapeutics Committee meetings and recorded in the minutes. It was positive to find that the Infection Control Preventionist Nurse had begun attending the Pharmacy and Therapeutics Committee meeting to review the effectiveness of the use of antibiotics. She attended the 9/20/2011 Pharmacy and Therapeutics Committee meeting and provided a report on the results of the Antibiogram analysis for antibiotics prescribed 8/1/2011 through 8/31/2011. An example of the analysis revealed that eight infections (one wound and seven urinary tract infections) were due to the Escherichia coli (e-coli) organism. The percentage of effectiveness of the antibiotics prescribed to treat those infections included: Levofloxacin - 25%; Amoxicillin – 38%; and Sulfamethoxazole – 75%. This information was important for providers to know to ensure that the most appropriate and effective antibiotics are prescribed to treat specific organisms for the Facility's population. In addition, this meets the Settlement Agreement and Health Care Guidelines requirement that the Infection Control Department and Pharmacy Department monitor antibiotic prescribing practices. Although there had been some improvements made, this provision was not found in compliance but found to be close to meeting compliance. In order to meet compliance with this provision of the Settlement Agreement, the positive practices indentified in the report must be maintained and improvements made in other practices. The Nursing Department should make the following improvements: • The Nursing Department in collaboration with the Quality Assurance Department should establish an inter-rater reliability system to ensure the accuracy of the medication administration observation data. • The Nursing Department should collaborate with the Physical and Nutritional Management Team to ensure that the PNMPs include medication administration instructions for individuals who are at risk for choking and/or aspiration, have altered diet texture/consistency, and special instructions for dining, positioning, eating utensils/equipment. • The Nursing Department should monitor the Medication Administration Nurses' Signature Sheets to ensure that all nurses listed have signatures and titles documented. If there are nurses' names listed who are not working, they should be removed.	

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		• The Nursing Department in collaboration with the Quality Assurance Department should develop a narrative explanation for the medication error/variance data, to include improvement and regression data similar to the other Quality Assurance/Quality Improvement data reports for other monitoring tools. • The Nursing Department should ensure that number and description of medication errors/variances; and the disposition of discussion and plans of corrective action, as well as the effectiveness of such actions, are reported at the Pharmacy and Therapeutics Committee meetings and recorded in the minutes. • It is essential that the Nursing Administration and Nursing Management critically review and investigate all Medication Error Reports to ensure: o The accuracy of the reports, including correctly rating the error Category. o Timely reporting, discovery, and notification to the physician of errors. o Timely implementation of corrective action with the nurse committing the error. o Systemic issues are identified and addressed so as to minimize medication errors. o Each error is reported separately as opposed to combining multiple errors on one report.	

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

1. The Nursing Department should ensure that established nursing ratios for the units and Infirmary are consistently met. (Provision M.1)
2. The Nursing Department should consider making the following improvements: (Provision M.1)
   - Ensure that all nursing auditors rating the nursing monitoring tools are clinically competent and that there is consistency between auditors. Collaborate with the Quality Assurance Department to develop a formal method for conducting inter-rater reliability checks and to measure the effectiveness of the process. (Provision M.1)
   - Collaborate with the State Office to develop specific instructions for each of the Nursing Care Monitoring Tools. (Provision M.1)
   - Collaborate with the Quality Assurance Department and State Office to develop a system for "weighting" each data item on the monitoring tools by value of significance, where appropriate. This will aid in prioritizing the most critical items that need CAPs. (Provision M.1)
   - Develop CAPs for specific problems identified through monitoring specific units, shifts and/or other localized situations, as well as CAPs for systemic problems identified through the broader analysis of trend data. (Provision M.1)
3. Facility should consider making the following improvements to the Infection Control Program: (Provision M.1)
   - The Infection Control Preventionist Nurse should collaborate with Facility providers and the contract Infection Control Physician to establish a protocol for identifying and managing trends based on rates of infections.
   - The Infection Control Preventionist Nurse needs to ensure the status of individuals' tuberculosis screenings and immunizations are tracked, as well as collaborating with providers to ensure they are up to date.
   - In order for the surveillance monitoring data to be useful, facility-wide, for internal management purposes, and to demonstrate compliance with this provision, the Infection Control Preventionist Nurse should: analyze, trend, develop and implement corrective action plans for identified deficiencies, evaluate their effectiveness, and report findings in the Infection Control Committee Reports, as well as other required Facility reports.
4. Facility should consider making the following improvements to the Emergency Response system: (Provision M.1)

- Post signs throughout the Facility to identify the location of emergency equipment.
- Add response times, initially and during the drills to the Mock Medical Emergency Drill sheets.
- Ensure that all required staff remain current in CPR training.
- Ensure that all required staff receive training on the revised Emergency Response Policy, 9/7/2011.
- Ensure that when additional emergency response training is provided that the percentages of staff trained are tracked to ensure all required staff have completed the required training. The results of the trainings completed should be reported in the Drill Committee minutes and/or in other relevant reports.
- Ensure that the nursing staff consistently checks all Control Drug Check Sheets and Emergency Equipment according to Facility policy. The Drill Committee should also review and analyze the emergency equipment to identify problems/trends resulting from incomplete checks of emergency equipment and develop CAPs when appropriate.

5. The Nursing Department should make the following improvements: (Provision M.2)
   - Ensure that the RN Case Managers understand the timelines required by the PSP schedule for completing the Annual/Quarterly Nursing Assessments and that they maintain a current PSP schedule for completing the assessments.
   - Ensure that the RN Case Managers review individuals' finalized PSP and PSPA plans for accuracy and completeness related to the corresponding nursing's health care plans.
   - Ensure the RN Case Managers notify the PST when individuals refuse to allow physical assessment and/or vital signs after reasonable effort has been made to resolve the problem.
   - Ensure for individuals who are in the hospital when their Annual/Quarterly Comprehensive Nursing Assessments are due that the assessments are completed upon discharge home.
   - Develop and implement a standardized format to use for completing the overall nursing summaries on the Comprehensive Nursing Assessments template.
6. The effectiveness of the use of the Health Care Protocols for Developmental Disability Nurses to develop individualized care plans should be further explored by the Nursing Administration and Management staff and/or the SSLC Nurse Workgroup. (Provision M.3)
7. The Nursing Department should make the following improvements: (Provision M.3)
   - Ensure that HMPs are integrated with other relevant disciplines to meet the individuals' total health care needs.
   - Ensure that HMPs have clinically appropriate goals/objectives that are realistic and measurable in relation to the identified health problems.
   - Ensure that HMPs are individualized to meet individuals' unique health care needs.
   - Ensure that the HMPs include proactive interventions that are directed at preventing or minimizing the specific health risks. The interventions need to provide specific instructions for how frequently they are carried out, by whom, and where to document nursing actions.
   - Ensure the RN Case Managers continuously evaluate the effectiveness of the HMPs, particularly when individuals' problems are not resolving or minimizing. When the HMPs are not found effective they need to be revised and re-evaluated. The effectiveness of the HMPs need be documented in individuals' records and summarized in their Annual/Quarterly Comprehensive Nursing Assessments.
8. The Nursing Department should make the following improvements: (Provision M.4)
   - Ensure that all required nurses receive training on existing and any newly developed and implemented nursing policies, and procedures, protocols, and processes.
   - Track all nursing training provided for internal management purposes, as well as to demonstrate compliance with this provision of the Settlement Agreement. Further, all training completed and tracked by Nursing Administration/Management should be centrally maintained in the Nursing Education Department.
9. The Nursing Department should ensure that the RN Case Managers, and other relevant nursing staff consistently meet all criteria contained in the At Individual Risk Policy and associated documents. (Provision M.5)
12. The Nursing Department in collaboration with the Quality Assurance Department should establish an inter-rater reliability system to ensure the

accuracy of the medication administration observation data. (Provision M.6)

13. The Nursing Department should collaborate with the Physical and Nutritional Management Team to ensure that the PNMPs include medication administration instructions for individuals who are at risk for choking and/or aspiration, have altered diet texture/consistency, and special instructions for dining, positioning, eating utensils/equipment. (Provision M.6)
14. The Nursing Department should monitor the Medication Administration Nurses' Signature Sheets to ensure that all nurses listed have signatures and titles documented. If there are nurses' names listed who are not working, they should be removed. (Provision M.6)
15. The Nursing Department in collaboration with the Quality Assurance Department should develop a narrative explanation for the medication error/variance data, to include improvement and regression data similar to the other Quality Assurance/Quality Improvement data reports for other monitoring tools. (Provision M.6)
16. The Nursing Department should ensure that number and description of medication errors/variances; and the disposition of discussion and plans of corrective action, as well as the effectiveness of such actions are reported at the Pharmacy and Therapeutics Committee meetings and recorded in the minutes: (Provision M.6)
17. It is essential that the Nursing Administration and/or Nursing Management review Medication Error Reports on errors committed by the nursing staff to ensure they are completed correctly, and that prompt corrective action is taken and documented on the form for the nurse committing the medication error.

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. DSSLC Plan of Improvement 9/7/11 2. Drug Intervention Guidelines, dated July 11, 2011 3. Most recent drug intervention communications for Individuals #351, #621, #210, #92, #28, #627, #61, and #372 4. Intervention Summary, June 2011 5. Most recent QDRR, most recent laboratory studies, and associated medication list for Individuals #453, #743, #416, #285, #85, and #510 6. Benzodiazepine Policy Guidelines, dated June 1, 2011 7. Chemical restraint which includes a restraint checklist, and Face-to-Face Assessment, Debriefing and Review for Individuals #624 and #306 8. P&TC minutes for May and July, 2011 9. Pharmacy Metabolic Syndrome Monitoring Policy, dated August 26, 2011 10. Benzodiazepine data tracking for May, 2011 through July 2011 11. Benzodiazepine Policy Guidelines, dated June 1, 2011 12. Past six Months MOSES and DISCUS reports for Individuals #21, #551, #587, #512, #494, #395, #114, #12, #138, and #285 13. Adverse Drug Reaction Reporting Tracking for March through August., 2011 14. Process for Adverse Drug Reaction Reporting Policy 34.1, revised 8/23/11 15. Potential Adverse Drug Reaction (ADR) Reports for March 2011, through July 2011 16. ADR Form, progress notes and Questionnaire for Individuals #298, #793, #20, #702, #701, and #416 17. Policy #35.1, Drug Utilization Policy, dated July 8, 2011 18. Zocor Drug Utilization Evaluation, dated August 2011 19. Insulin Drug Utilization Evaluation, dated July 2011 20. Medication Error Tracking and Procedures Policy, number 27.1, dated June 21, 2011 21. Medication Excess Forms, not dated 22. Medication Shortage Forms, not dated 23. Medication Error Index Form, not dated 24. Procedures for Communicating Drug Interactions, not dated 25. Pharmacy Dispensing Errors Log, not dated 26. Medication Variance Committee minutes, dated September 2, 2011 27. Intraclass polypharmacy report, 7/11 **People Interviewed:** 1. Jana Boone, Pharmacy Director **Meeting Attended/Observations:** 1. None
	Facility Self-Assessment:

	The Facility's POI, dated 9/7/2011, provided status update on Provisions N1 through N8. The Facility reported substantial Compliance with Provisions N1, N2, N3, N5, N6, N7 and N8, and noncompliance with Provision N4 of the Settlement Agreement. The Monitoring Team concurred with the Facility and determined substantial compliance with Provision N1, N2, N6 and N7, and disagreed with the Facility's self assessment of compliance with Provision N5 and N8. The Facility reported noncompliance with Provision N4, which was consistent with the Monitoring Teams findings. The POI provided the Monitoring Team with little information on how the Facility is working towards compliance. The POI should outline a plan consisting of action steps, not merely a list of actions completed. Provision N1: The Facility reported substantial compliance with Provision N1, stating that it initiated a drug intervention guideline and a process that ensures pharmacists address new medication orders. The Monitoring Team concurred with the Facility's assessment. Provision N2: The Facility reported noncompliance with Provision N2, stating that they had yet to hire a fulltime pharmacist to conduct QDRRs, but were in the process of hiring a pharmacist in the near future. The Monitoring Team concurred with the Facility's assessment. Provision N3: The Facility reported substantial compliance with Provision N3, and reported completing many tasks, as outlined in the Facility's POI. The Monitoring Team recognized several areas that require continued enhancement in the area of monitoring for anticholinergic medications, polypharmacy, and STAT medication use; therefore the Monitoring Team determined that the Facility remained noncompliant with the N3. Provision N4: The Facility reported noncompliance with Provision N4 because they lack meaningful recommendations on QDRRs. The Facility reported that after hiring a clinical pharmacist, QDRRs will improve and the Facility will ensure physician follow-up to recommendations. The Monitoring Team concurred with the Facility's self-assessment and plan of improvement. Provision N5: The Facility reported substantial compliance with Provision N5, and reported that all MOSES and DISCUS assessments were up to date. The Facility reviewed QDRR's and found that 97% of all QDRRs noted that MOSES and DISCUS assessment were current. The Monitoring Team disagreed with the Facility's self-assessment because evidence substantiated that more frequent monitoring for TD was not conducted as clinically indicated. Provision N6: The Facility reported substantial compliance with Provision N6. The Facility reported it will initiate training on signs and symptoms of health status, which includes observing for adverse drug reactions (ADRs). This training will be provided to all current direct care staff and all new direct care staff upon their hire. All ADRs are to be tracked by pharmacy and reported to the P&TC for review. The Facility reports an increase in ADR reports from the living areas. In the past six months, 11 ADRs were reported. The Monitoring Team concurs with the Facility's self-assessment and determined the Facility to be in substantial compliance with Provision N6.

	Provision N7: The Facility reported substantial compliance with Provision N7. The Facility developed a formal Drug Utilization Policy, which clearly outlines the Facility's process in establishing and providing Drug Utilization Evaluations (DUEs). The P&TC is charged with identifying at least four DUEs to be completed each year, one per quarter. In addition to regularly scheduled DUEs, the Facility will initiate addition DUEs when clinically necessary. Two DUEs were provided in July and August 2011. Importantly, the Facility does individual DUEs at the time of initiating new medication orders. Provision N8: The Facility reported substantial compliance with Provision N8. The Monitoring Team was unable to assess the Facility's plan of improvement because the POI was a mere checklist of all of the activities completed by the Facility for Provision N8, but did not provide a meaningful outline of action steps which were necessary to achieve compliance.
	Summary of Monitor's Assessment: Provision N1: Given that the process for monitoring new medication orders includes an informative guideline, appropriate pharmacy interventions, and that pharmacy interventions were reviewed by P&TC, and by the Director of Pharmacy, the Monitoring Team determined that the Facility's process was sound and met expectations of the Settlement Agreement; hence, the Facility was determined to be in substantial compliance with Provision N1. Provision N2: The Monitoring Team was made aware that the Facility recently hired a fulltime pharmacist to conduct QDRRs, and was deficient with completing QDRRs due to the need for additional staff. Importantly, the Monitoring Team noted that the QDRR process at the Facility did not meet standard of care practice, as required by the Settlement Agreement. It is essential that the Facility develop a process that ensures each QDRR is completed per standard of care practice, and that there is a mechanism to perform Quality Assurance outcomes for the QDRR process. The Monitoring Team therefore concurs with the Facility of noncompliance with the Provision. Provision N3: The Facility had made significant improvements towards compliance with Provision N3. The Facility developed an excellent Metabolic Screening Policy, developed an excellent review process for benzodiazepines, thoroughly reviewed intra-class polypharmacy, and had an excellent process to assess chemical restraints. However, because there was no mechanism in place to address anticholinergics, not yet implementing their new Metabolic Screening Policy, failure to develop and implement a mechanism to address STAT medications, and not fully addressing polypharmacy, the Monitoring Team determined that the Facility is not in compliance with Provision N3. Provision N4: The Monitoring Team concurs with the Facility's self-assessment and determined the Facility to remain noncompliant with Provision N4. To obtain substantial compliance, the Facility must enhance its QDRR process, as outlined in Provision N2, and ensure that meaningful recommendations are made for physician review, then ensure appropriate follow-up, and ensure that recommendations are addressed.

	Provision N5: Because tardive dyskinesia (TD) was not assessed more frequently when clinically indicated, the Monitoring Team disagrees with the Facility's self-assessment of being in substantial compliance, and determined that the Facility remains noncompliant with Provision N5. The Monitoring Team was also concerned with result of the DISCUS and MOSES assessments, which for the most part indicated no side effects. Given the many physical anomalies that many of the individuals are known to have, and the amount of polypharmacy experienced by Individuals at the Facility, one would expect more adverse findings following an assessment. The Monitoring Team will evaluate outcomes of MOSES and DISCUS assessments on subsequent reviews. Provision N6: The Monitoring Team concurs with the Facility's self-assessment and determined the Facility to be in substantial compliance with Provision N6. The determination was based on a functional policy that delineates the ADR process, meaningful training of staff, and an efficacious review process. Provision N7: Because the Facility has a comprehensive policy for conducting DUEs, and because the Facility had provided meaningful DUEs during the past six Months, and because all new medication orders are evaluated though a DUE process, the Monitoring Team concurs with the Facility's self-assessment and determines the Facility to be in substantial compliance with Provision N7. Provision N8: The Monitoring Team determined that the Facility was not in compliance with Provision N8 because its Medication Variance process was not well integrated among nursing, pharmacy and physician services, and because a meaningful review of medication variances was not provided by the Medication Variance Committee.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the	Pharmacy had initiated many new activities, as outlined in the POI. A Drug Intervention Guidelines document, dated July 11, 2011, was developed and implemented. This guideline provides pharmacists concise information on how to follow up on medication orders and related responsibilities, to help ensure that new medication orders are reviewed for allergies, contraindications, unnecessary and duplicate therapy, compatibility, and to ensure that appropriate diagnostics, such as blood levels have been ordered. The pharmacist responds to all identified issues by generating a Drug Intervention Report, and follows up by phone call or email with the prescribing clinician. The Director of Pharmacy reviews interventions, generates an excel spreadsheet (Intervention Summary, June 2011) for tracking interventions, and reviews interventions each month with the pharmacists, Pharmacy & Therapeutic Committee (P&TC), and when necessary, with the Medical Director. The Monitoring Team reviewed the Intervention Summary for June 2011, and noted its completeness. The last Intervention notification to prescribing physicians for the following individuals was reviewed by the Monitoring Team: Individuals #351, #621,	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	#210, #92, #28, #627, #61, and #372. The communications were well documented, and appropriate. Given that the process includes an informative guideline, interventions were reviewed by P&TC and monthly by the Director of Pharmacy, the Monitoring Team determined that the process is sound and meets expectations of the Settlement Agreement; hence, the Facility was determined to be in substantial compliance with Provision N1.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	The Pharmacy Director reported that the Facility remains noncompliant with Provision N2, because they were unable to hire a fulltime clinical pharmacist to conduct their Quarterly Drug Regimen Reviews (QDRRs). Since the last on-site review, the Facility posted a hiring request for a full time clinical pharmacist, and filled the position in September, 2011. The newly hired clinical pharmacist was to start completing QDRRs late September. The Monitoring Team recognized that the Facility would have only one pharmacist assigned to the QDRR process, as well as having many other duties. Following its review of six QDRRs for Individuals #453, #743, #416, #285, #85, #510, the Monitoring Team concluded that the Facility's review process was not consistent with current, generally accepted professional standards of care. Standard of care practice dictates that at a minimum, a QDRR consists of a thorough evaluation of medications, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication use. The review process should include preventing, identifying, reporting and resolving medication related problems, medication errors, and collaborating with members of the interdisciplinary team. It is essential that medications be adequately assessed for efficacy, especially in the area of psychotropic, and anticonvulsant medications. There was no evidence observed or provided that demonstrated a comprehensive review of medications, that included a chart review, and, when necessary, discussion with staff, prescriber, or other team members, review of behavior and seizure data, or assessment of the individual. The Facility's QDRR process did not meet standard of care practice when completing QDRRs; therefore the Monitoring Team has concluded that the Facility remains non-compliant with Provision N2. The Facility must enhance its QDRR process by conducting a comprehensive clinical review of all medications, as they relate to the total care of the individual. The Monitoring Team was most impressed with the Facility's review of their QDRR process, as part of the P&T Committee. The P&T Committee meeting minutes, dated May 24, 2011, delineated identified issues, which corroborated the Monitoring Teams independent review. Critical assessments, such as performed in this case, will strengthen the Facility and system, and ensure that quality supports and services are delivered to Individuals residing at the Facility. Most importantly, outcomes will improve.	Noncompliance

#	Provision	Assessment of Status	Compliance
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	Pharmacy had yet to develop a policy, procedure or functional mechanism to regularly and meaningful review the use of anticholinergic medications. The Director of Pharmacy reported that the Facility is diligently working towards a resolution for this issue. There was no data or information for the Monitoring Team to review. The Monitoring Team reviewed the Facility's process for assessing chemical restraint use. The Pharmacy reported that a comprehensive report is generated for each use of chemical restraint; this report includes a restraint checklist, and Face-to-Face Assessment, Debriefing and Review. The Face-to-Face assessment includes a summary by the prescribing physician. The Monitoring Team reviewed the associated reports for each of the two chemical restraints (Individuals #624 and #306) that occurred during the past six months, and found the reports to be comprehensive and clinically appropriate. The Monitoring Team noted that the P&TC specifically reviewed the use of chemical restraint and considered appropriateness. The Monitoring Team determined that the P&TC review met the minimum requirement to achieve substantial compliance but recommends enhancing its review by incorporating data analysis for the frequency of chemical restraint Facility-wide and individually. The Settlement Agreement specifically requires that there is a process to assess STAT medications. The use of STAT medications was not specifically addressed by the Facility. STAT medications not only include psychotropic medications for behavioral issues, but also general medical purposes, such as treating hypoglycemia, status epilepticus, and hypertensive urgencies. The Facility developed an excellent guideline for the use of benzodiazepines at the Facility, "Benzodiazepine Policy Guidelines," dated June 1, 2011. Physicians, along with pharmacy, had input on the development of this guideline. There was no process to ensure that newly hired physicians are provided this guideline. The Director of Pharmacy Services reviewed the use of benzodiazepines by collecting data and reviewing clinical indications, and presented findings at the Polypharmacy meeting. The Monitoring Team reviewed benzodiazepine data tracking for May 2011 through July 2011. Data were collected by means of a spreadsheet, and tracking was comprehensive. Data graphs were generated, but the x and y axes were not labeled. Since tracking benzodiazepine use began, usage at the Facility had substantially decreased, but it has plateaued over the past six months, at 39 individuals currently being prescribed benzodiazepines. Following review of minutes from the May 2011, and July 2011 P&TC minutes, the Monitoring Team noted that the P&TC committee did not review benzodiazepines. There were no minutes provided to the Monitoring Team indicating a review of benzodiazepines by the Polypharmacy Committee.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The Facility developed an excellent policy for pharmacy to monitor Metabolic Syndrome. At the time of this review, however, the policy had not been implemented. There was no clinical data for the Monitoring Team to review to assess compliance. The Facility maintained a Polypharmacy Committee that reports to the P&TC. The Facility did not have an updated policy or procedure on the Committee structure and function. The Facility provided the Monitoring Team a series of reports generated by the Polypharmacy Committee entitled "Intra-Class Poly Pharmacy Report" for May and June, 2011. The report indicated that Medical and Pharmacy departments participated at the Polypharmacy Committee. The Monitoring Team noted excellent review for "intra-class polypharmacy"; however, the reports covered only psychotropic polypharmacy, and other forms of polypharmacy where not included in the reports. Importantly, the Committee did not report on general trends of polypharmacy for individuals and for the Facility; the focus was on individual cases and needs also to include review of system issues. The Facility had made significant improvements towards compliance with Provision N3. The Facility developed an excellent Metabolic Screening Policy, developed an excellent review process for benzodiazepines, thoroughly reviews intra-class polypharmacy, and has an excellent process to assess chemical restraints. To reach compliance, the Facility will need to implement a mechanism to address anticholinergics, implement the Metabolic Screening Policy, develop and implement a mechanism to address STAT medications, and fully address polypharmacy.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	The Facility reported that its QDRR process remained inadequate because of lack of a full time clinical pharmacist and inability to provide physicians with meaningful recommendations. Since the recent hire of a fulltime clinical pharmacist, the Facility expects to gain compliance in this area in the near future. The Monitoring Team concurs with the Facility's assessment and concern of not completing meaningful QDRRs, as elaborated in Provision N2, of this report. Because of the limited nature of the QDRR process, the Monitoring Team could not assess physician compliance with recommendations for issues noted on QDRRs. The Monitoring Team did note, however, that physician response to pharmacists recommendation for new medication orders, as outlined in Provision N1, of this report, was consistent and appropriate. The Monitoring Team reviewed Intervention Reports and communications for medication orders for Individuals #351, #621, #210, #92, #28, #627, #61, and #372, and noted timely, and appropriate responses by physicians.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The Monitoring Team concurs with the Facility's self-assessment and determined the Facility to remain noncompliant with Provision N4. To obtain substantial compliance, the Facility must enhance its QDRR process, as outlined in Provision N2, and ensure that meaningful recommendations are made for physician review, then ensure appropriate follow-up, and ensure that recommendations are addressed.	
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.	The Facility reported that it provided training on MOSES and DISCUS to nurse case managers. Training was also provided to direct support staff on how to monitor for Tardive Dyskinesia (TD) and is now a component of new employee orientation training. The Monitoring Team requested the past six months of MOSES and DISCUS assessments for ten individuals who had a recent addition of a neuroleptic (Individuals #21, #551, #587, #512, #494, #395, #114, #12, #138, and #285). In all cases reviewed, more frequent monitoring for TD, as clinically necessary, was not conducted by the Facility. More frequent monitoring for TD is necessary when ever there is a addition, discontinuation or dose change of a neuroleptic. The assessments were completed a routine bases. Whenever a neuroleptics medication is initiated, discontinued or dose changed, TD must be more frequently assessed. Another issue to consider when monitoring for TD, is when non-neuroleptic medication changes occur that may alter the blood level of the neuroleptic. In such cases, the unmasking of TD may occur. It should be noted that the MOSES for Individual #494, dated August 30, 2011, was signed by the prescriber on August 8, 2011. The DISCUS performed on Individual #494, dated 5/23/11, was not reviewed by the prescriber until 8/31/11. Because TD was not assessed more frequently when clinically indicated, the Monitoring Team disagrees with the Facilities self-assessment of being in substantial compliance, and determined that the Facility remains non-compliant with Provision N5. The Monitoring Team was also concerned with result of the DISCUS and MOSES assessments, which for the most part indicated no side effects. Given the many physical anomalies that many of the Individuals are known to have, and the amount of polypharmacy experienced by Individuals at the Facility, one would expect more adverse findings following an assessment. The Monitoring Team will evaluate outcomes of MOSES and DISCUS assessments on subsequent reviews.	Noncompliance
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all	To assess the Facility's methods to address Adverse Drug Reactions (ADRs), the Monitoring Team reviewed the revised local policy, Process for Adverse Drug Reaction Reporting, dated 8/23/11, and noted its appropriateness and completeness. The Adverse Drug Reaction Reporting Tracking form, for March through August, was reviewed, and it was noted that a total of 11 ADRs were reported and reviewed by the Facility during that time frame. The ADR Reporting Tracking form was based on an Excel	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	significant or unexpected adverse drug reactions.	Spreadsheet, and was informative. The Monitoring Team assessed the Facility's review of the past six ADRs by reviewing the Adverse Drug Reaction Forms, Questionnaires and associated progress notes for Individuals #298, #793, #20, #702, #701, and #416, and found all documents to be comprehensive and enabled insight into the clinical nature of the ADR. There were two, non-critical, omissions noted: The ADR questionnaire for Individual #702 was not dated, and the ADR report and Questionnaire for Individual #701 was not signed or dated by the person who completed the forms. Of primary concern was the continued low frequency of ADR reports by the Facility. Given the number of Individuals and the significant number of medications administered, one would conclude that ADRs should be higher then reported. The Director of Pharmacy, Jana Boone, concurred with the Monitoring Teams concern and reported that she expects additional reporting to occur as more staff are trained on the ADR process. The Monitoring Team concurred with the Facility's self-assessment and determined the Facility to be in substantial compliance with Provision N6. The determination was based on a functional policy that delineates the ADR process, meaningful training of staff on the ADR process, and an efficacious review process.	
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 determine compliance with Provision N7, the Monitoring Team reviewed the Facility's process with the Director of Pharmacy, reviewed its new policy for the Drug Utilization Evaluations (DUEs) Process, and reviewed the past two DUEs provided by the Facility. The Monitoring Team noted that the Policy clearly delineated a process that ensured at least a quarterly DUE for a medication or medications identified by the P&T committee. In addition, the Facility will provide additional DUEs when clinically relevant, such as in the case of new FDA warnings, identification of adverse drug outcomes, or other clinical need. The Facility's DUE process will enable the Facility to make clinical and administrative recommendations, policy changes, training of staff, changes in prescribing habits, alteration of dispensing and medication administration, and provide general information about medication use at the Facility. The Monitoring Team reviewed two recent DUEs entitled Zocor Drug Utilization Evaluation, dated August 2011, and Insulin Drug Utilization Evaluation, dated July 2011. The Monitoring Team was impressed with the scope and review process of the two DUEs. Importantly, the Facility continues to provide a Drug Utilization Evaluation prior to	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		approving any new medication order at the Facility. Because the Facility had a comprehensive policy for conducting DUEs, and because the Facility had provided meaningful DUEs during the past six Months prior to this review, and because all new medication orders are evaluated though a DUE process, the Monitoring Team determined that the Facility is in substantial compliance with Provision N7.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	The Facility provided the Monitoring Team with a new policy called the Medication Error Tracking and Procedures Policy, number 27.1, dated June 21, 2011; Medication Excess Forms; Medication Shortage Forms; a Medication Error Index Form; Procedures for Communicating Drug Interactions; and a Pharmacy Dispensing Errors Log. The Medication Variance Committee minutes, dated September 2, 2011, were also reviewed. The Monitoring Team discussed details of the Facility's Medication Variance process with the Director of Pharmacy, Jana Boone, and reviewed findings from Section M6, of this report. Based on this review, the Monitoring Team noted that the Facility's Medication Variance Process was not unified under a single monitoring entity, and that Physician Services was not actively involved in the medication variance process. Prescriber variances, such as illegible scripts, incorrect demographics, wrong dates, wrong medications, not addressing allergies and known contraindications, must be included as a medication variance. Dispensing and administration variances must also be included. At the time of this review, the medication variance process was not well integrated. Importantly, as well delineated in section M6, of this report, the Medication Variance Committee did not assertively or meaningfully review medication variances. The Monitoring Team determined that the Facility was not in compliance with Provision N8 because its Medication Variance process was not well integrated among nursing, pharmacy and physician services, and because a meaningful review of medication variances was not provided by the Medication Variance Committee.	Noncompliance

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

1. Immediately develop a process to ensure that QDRRs are conducted at the level of standard of care practice. See Provision N2, of this report for additional details on requirements for QDRRs (Provision N2)
2. Develop a formal process for reporting and responding to the use of benzodiazepines, and ensure that appropriate committee's review and action on issues related to benzodiazepines (Provision N3)
3. Ensure that all graphs are appropriately labeled (for all data elements presented in graph form) (Provision N3)
4. Immediately implement the Metabolic Syndrome Monitoring Policy and ensure that QDRRs include the Metabolic Review in their assessment, as

outlined in the new Policy (Provision N3)
5. Ensure that physicians and pharmacist are trained on the benzodiazepine policy at time of hire and when necessary (Provision N3)
6. Enhance the polypharmacy committee to review and identify all types of polypharmacy, and ensure that general trends are assessed for the Individual and for the Facility as a whole (Provision N3)
7. When enhancing the QDRR process, establish a robust mechanism to ensure that recommendations are followed by Physician (Provision N4)
8. Ensure that MOSES and DISCUS are competed more frequently when clinically indicated (Provision N5)
9. Ensure that DUEs are provided whenever clinically necessary, not only quarterly (Provision N7)
10. Medication variances must be fully addressed under one entity, which includes reviewing variances and potential variances of prescribers, dispensing and administration variances. The Facility should re-evaluate its current medication variance process and develop a process that integrates nursing, pharmacy and physician services and attend to the requirements of the Provision (Provision N8)
11. Ensure that the Medication Variance Committee develops a robust process that meaningfully reviews medication variances, provides necessary recommendations and training, and when necessary initiates remediation (Provision N8)

The following are offered as additional suggestions to the Facility:
1. It would be advantageous to convert current spreadsheet data, into a database type solution. The volume of information being maintained in the spreadsheet will be considerable and retrieving and manipulating data fields will soon become rate limiting (all relevant provisions)
2. The DADs system should consider unifying a process for Provision N3, to ensure that QDRRs are completed per standard of care practice, and include a QA process, ensuring that pharmacists complete QDRRs appropriately.
3. Consider enhancing the P&TC review of chemical restraints, but incorporating a trends analysis review for the chemical restraints at the Facility level and at the level of the Individual.
4. Consider providing trends analysis when reporting on ADRs to the P&TC (N6)
5. Consider eliminating words such as medication errors and near misses. Use consistent terms such as medication variance and potential medication variance.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Documents Reviewed: **Steps Taken to Assess Compliance:** 1. DSSLC Plan of Improvement (POI), dated 9-7-2011 2. Record reviews: • Sample 1: Individuals #3, #20, #117, #211, #291, #336, #366, #504, #511, #519, #551 and #599 • Sample 2: Individuals #11, #37, #118, #272, #401, #466, #478, #557, #576, and #760 • Sample 3: Individuals #62, #111, #252, #352, #394, #460, #497, #502, #509, and #552 • Sample 4: Individuals #52, #59, #270, #413, and #496 3. A list of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management team (PNMT) members, including credentials 4. DSSLC PNM Policy (Draft) 012.2 5. A list of continuing education sessions or activities participated in by PNMT members since last review (3/2011) 6. Minutes, including documentation of attendance, for the PNMT meetings for the past 6 months 7. Individual PNMT reports as available for individuals reviewed above 8. Tools used to screen and identify individuals' PNM health risk level 9. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order 10. A list of PNM assessments and updates completed in the last two (2) quarters 11. PSPs for the sample individuals 12. Completed Physical Nutritional Management Plans (PNMPs) for all sample individuals 13. Tools used to monitor implementation of PNM procedures and plans 14. A list of individuals for whom PNM monitoring tools were completed in the last quarter 15. Tools utilized for validation of PNM monitoring 16. 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 17. PNMP template and any instructions for use of template 18. Dining Plan template 19. PNM spreadsheets generated by the Facility 20. Lists of individuals: (a) On modified diets/thickened liquids; (b) With BMI equal to greater than 30; (c) With BMI equal to less than 20; (d) Since March 2011, who have had unplanned weight loss of 10% or greater over six (6) months; (e) During the past six months, have had a choking incident; (f) During the past six months, have had a pneumonia incident;

	(g) During the past six months, have had skin breakdown; (h) During the past six months, have had a fall; (i) During the past six months, have had a fecal impaction; (j) 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.); (k) With poor oral hygiene; and (l) Who receive nutrition through non-oral methods 21. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation since the last review 22. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials 23. Tools and checklists used to provide competency-based training addressing: (a) Foundational skills in PNM; and (b) Individual PNM and Dining Plans 24. Since the last review, a list of competency-based training sessions addressing foundational skills in PNM **People Interviewed:** 1. Donna Groves OTR Director of Habilitation Therapies 2. Staci Kraus-RN-PNMT RN 3. Seven DCPs (4 Cedar Falls and 3 Houston Park) **Meeting Attended/Observations:** 1. PNMT meeting 9-19-11 2. At Risk Meeting (Individuals #306 and #42) 3. Mealtime and Transition Observations (Cedar Falls, Houston Park, Eastfield, Timberhill and Westridge)
	Facility Self-Assessment: DSSLCC Plan of Improvement, updated 9/7/2011, provided comments/status for Sections O.1 through O.8 of the Settlement Agreement. The Facility indicated it was in noncompliance with all provisions. The findings of DSSLC were consistent with the Monitoring Team's findings as all provisions were found to be noncompliant. The POI also provided a summary of some of the action plans on which the Facility was working to achieve compliance. The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the eight provisions but did not provide a clear sequential framework in which they expected to reach compliance. The current format listed activities, but did not present clear steps and strategies required to meet the provisions with timelines of completion. This kind of format would offer more of a roadmap for all staff and a means to direct their focus, effort, and energy. The majority of statements present focused on general status and activities; however, some data were provided that was gathered from the completion of the SA monitoring assessment and observations. DSSLC

	was using this data to assist them in determining if gains were being made as a result of their efforts. An issue with the process was the small sample in which the tool was utilized. DSSLC was aware of this issue and were working towards resolution. Expansion of the sample size for DSSLC's self assessment will be necessary for them to gain a better picture of their status with the agreement.
	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 was developed but had not been finalized and implemented as of this review. There was still no evidence that data were collected and the team was reviewing this 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 process that is intended to more accurately identify individuals at risk had been developed and implemented; however, lack of use of clinical judgment and critical thinking when the PSTs had to move beyond the guidelines often resulted in inaccurate assignment of risk. Individuals were not provided with comprehensive assessments in response to changes in status or as part of an annual assessment due to often referring to outdated tests and external assessments. Additionally; supports regarding the areas of oral care, head of bed assessment, bathing positioning, and medication administration were missing from the assessment process and were not comprehensively included in the PNMP. **Provision O.3:** This provision was determined to be not in compliance. PNMPs were not comprehensive due to the plans lacking information regarding oral care and medication administration strategies. While the plans did contain positioning for these activities, strategies intended to mitigate risk were lacking in detail thus resulting in an increased risk of variance when implementing the activity among multiple staff. **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 revised the monitoring

	form so that it would cover all aspects in which the individual was determined to be at increased risk; however, there was not a formal monitoring process in place nor was monitoring being implemented in all homes. **Provision O.7:** This provision was determined to be not in compliance. There was not a formal process in place that ensures individuals with increased PNM issues are provided with increased monitoring. **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 was completed as more of a review and did not investigate root cause of the issue resulting in hospitalization. Additionally, pathways to oral intake (PO) status and the implementation of oral motor strategies to improve oral control and maintenance was consistently not implemented or identified. Overall, while some improvement have been noted, primarily with the PNMT as well as the addition of a PNM nurse, DSSLC continued to fall short of making the strides needed to make substantial improvement in mitigating the risk associated with physical and nutritional supports. Lack of comprehensive assessment as well as lack of an organized and efficient PNM system will continue to result in a high occurrence of pneumonias and will place individuals at an unnecessary risk. Steps must be taken to ensure individuals who are identified as being at an increased risk of pneumonia are provided with a comprehensive assessment that focuses on all aspects of PNM (such as Medical, Habilitation Therapy, and Active Treatment) and identifies not only the current status but provides investigation into the etiology of the illness and/or risk. All interventions identified as being relative to mitigating PNM risk should have clear rationale as to what they address as well as what will be done to potentially withdraw that support I the future.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance	DSSLC had developed a Physical and Nutritional Management Team (PNMT) 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. The Physical and Nutritional Management Committee (PNMC), whose primary role was to look at systems issues, consisted of an Occupational Therapist (OT), Physical Therapist (PT), Physician (MD), Assistant Director of Programming (ADOP), Quality Assurance Director (QA), Director of Behavior Services, and a PNMT Nurse. Members of the PNMC included: • Stephen Kubala MD-Medical Director • Donna Groves OTR-Director of Habilitation Therapy • Delia Schilder RN-Chief Nurse Executive • Paula Horn PT	Noncompliance

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	with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	• Lori Powell QA director • Dora Tillis-Assistant Director of Program Services (ADOP) • Randy Spence-Director of Behavior Services • Staci Kraus-RN-PNMT RN The Physical and Nutritional Management Team (PNMT), which focused on clinical issues, consisted of: • Stephen Kubala MD-Medical Director • Donna Groves OTR-Director of Habilitation Therapy • Staci Kraus-RN-PNMT RN • Mary Kuhfelt RD • Paula Horn PT PNM Team attendance records from 04/4/2011 to 8/29/2011 documented consistent attendance by PNM Team standing members. The makeup of the PNMT was not in compliance with standards set forth by the Settlement Agreement due to the lack of a Speech Pathologist serving as a regular member of the team. A desire of DSSLC was to have a dedicated SLP for the PNMT but this was unaccomplished due to staffing. Another issue with the PNMT was that minutes were not gathered that provided clear evidence of discussion. Reports and actions plans were available but lacked the cohesiveness of a summary that minutes provide, therefore better being able to ensure all responsibilities and discussions are documented. Review of documentation of PNM clinical instruction submitted revealed opportunities for PNMT members to participate in trainings relevant to increasing their knowledge of PNM. The courses offered focused on: • Seating and Positioning for Dysphagia • PNMT-Assessment Technologies • PNMT-GI/Dysphagia • DADS Habilitation Therapies Conference Other conferences attended by members of the PNMT included Therapeutic Tai Chi for Fall Prevention and Physical Therapy Treatment Ethics. Due to the importance of PNM, continuing education in the field of PNM should be mandatory for all members of the team and should extend beyond the trainings provided by State Office (SO) or in house staff.	

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		Frequency of the PNMT meetings was not clearly stated but upon review of PNMT signature sheets and per report of Donna Groves OTR Director of Habilitation Services, there were 40 meetings that occurred during the months of April, May, June, July and August 2011. Other than the state policy, the Facility had not developed a localized PNMT policy that defined the roles and responsibilities of the PNMT and the collaboration that was intended to occur with the Personal Support Team (PST). There was not a defined criterion that stated what incidents must be referred to the PNMT and what may be referred to the PNMT. A draft PNM policy was in development and should be implemented by the next compliance visit. There also was not a QA component to the PNMT in which data relevant to physical and nutritional supports are reviewed and analyzed by the team. Reviewing and identifying trends and the root cause of these trends will allow the PNMT to streamline and pinpoint trainings and/or assessments in an effort to prevent future occurrences, as well as identify other improvements and corrective actions that should be addressed. PNMPs were not in alignment with current best practice standards. For issues related to this component, please refer to provision O.3. PNMPs were not clearly developed with input from all members of the PST or reviewed consistently by the PST. For examples, please refer to provision O.3.	
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	There was extreme concern by the Monitoring Team regarding the high number of pneumonias that had occurred over the past 4 months. As of August 30, 2011, there were 78 individuals diagnosed with pneumonia. The amount of pneumonias was equivalent to approximately 15% of the total DSSLC population. The occurrence of this amount of pneumonia reflects on DSSLC's ability to identify and proactively treat individuals who were at an increased risk. Individuals for sample #1 were chosen from the list of individuals who were diagnosed with an aspiration and/or choking event over the past 6 months. The sample consisted of four individuals who accounted for 100% of the individuals who experienced a choking event and eight individuals who accounted for 42% of the individuals who experienced an aspiration event. The aspiration event portion of the sample was chosen by choosing every third name on the diagnosis list provided by DSSLC. Sample #2 consisted of 10 individuals who were chosen from a list provided by DSSLC of individuals who were identified as being at a high risk of choking or aspiration. The	Noncompliance

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	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.	sample was chosen by choosing every tenth name on the aspiration list and every fifth name on the choking at risk list. Sample #3 consisted of 10 individuals or 11% of the individuals at DSSLC who received enteral nutrition. The sample was chosen by selecting every eighth individual on the enteral nutrition list provided by DSSLC. Based on a review of 32 individuals' (sample #1, #2 and #3) most recent OT/PT assessments, zero of 32 Individuals (0%) were provided with a comprehensive assessment by the PNM team 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. The swallowing components of the OT/PT assessment were vague and did not provide consistent information regarding the impact on functioning. For example: • Individual #599's OT/PT assessment stated the individual demonstrates rotary chewing but did not describe spillage, pocketing, or residue or the lack thereof. • Individual #20's OT/PT assessment stated the individual has vertical chewing but did not provide the functional relevance of this issue. The Oral Care and Medication Administration sections of the OT/PT assessment were vague, missing or contained a general statement of positioning but did not contain any information indicating assessment of the areas. For example: • Individual #3's oral care section stated the positioning but did not provided any information regarding the acquisition of skills regarding this activity. • Individual #511's medication administration did not provide evidence of assessment in determining the need for crushed medications. A comprehensive PNMT evaluation was completed by the PNMT as based on referral by the PST. Components of this assessment included: • Reason for referral • Risk levels • Behavioral challenges • Medical problems • Medication side effects • History • Hospitalizations • Medications • Surgical procedures • Supportive care	

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		• PNM analysis and recommendations While the function of interventions was included in the assessments, zero of 22 (0%) (Sample #1 and #2) assessments reviewed contained clear investigation as to why interventions (e.g., adaptive equipment, bed elevation) were appropriate. For example: • Individuals #466, 478, and 576 were all recommended to have the head of their beds elevated; however, there was no evidence of assessment that clearly explained why the recommended degree of elevation was appropriate or individualized to the person. Also lacking from the assessment was evidence of multiple options for safe bathing resulting in individuals being assessed based on availability of type of equipment and not based fully on need. Based on a review of 12 (samples #1) records of Individuals who experienced an aspiration or choking event, 4 of 12 (33%) records reviewed accurately identified individuals who are at an increased risk of physical and/or nutritional decline. Examples of individuals not being appropriately identified include: • Individual #366 and #211 were identified as being at a "medium risk" of aspiration but per guidelines should have been listed as a "high risk" due to recent aspiration events. • Individual #511 was identified as being at a "medium risk" of choking but per guidelines should have been listed as a "high risk" due to a recent choking event. The PST had the ability to lower the risk; however, there was no evidence of the rationale behind the lower risk score. Lack of critical clinical thinking and discussion was noted when the PSTs had to move beyond the guidelines. This lack of clinical judgment impacted the risk scores and increased the likelihood of inadequate supports being provided to the individual. An example was Individual #599 who has oral dysphagia and a tendency to eat at a fast unsafe rate but was listed as only a medium risk. More information regarding the identification of risk may be found under section I. One of 12 (8%) individuals who were diagnosed and/or hospitalized with a PNM issue (sample #1) was assessed by the PNMT or PST. For example: • Individual #117 had a choking event on 8-15-11. On 8-16-11, the OT conducted an observation but there was no evidence of a tableside swallowing assessment. Additionally, the OT stated that findings and recommendations would follow but there was no evidence that this occurred. • Individual #519 was diagnosed with aspiration pneumonia on 4/11/11 but	

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		there was no evidence of comprehensive reassessment upon return from the hospital. There was evidence of the PST meeting to discuss the event but the discussion was limited to the need to defer programming and did not focus on potential indicators or triggers that led to the aspiration event. • Individual #211 was diagnosed with aspiration pneumonia on 6/6/11 but there was no evidence of comprehensive reassessment upon return from the hospital. The PST met on 6/11/11 and decided to defer programming until return from hospital. The team also stated that they would meet upon return from the hospital but there was no evidence that this occurred. There was some evidence of the PST meeting to discuss the event but the discussion was limited to the need to defer programming and did not focus on potential indicators or triggers that led to the aspiration event. Lack of critical thinking as mentioned above in identifying risk as well as lack of discussion surrounding aspiration events was alarming due to the high rate of aspirations occurring at DSSLC. Per review of the Pneumonia list provided by DSSLC, 78 episodes of pneumonia occurred during the last quarter accounting for approximately 15% of the population at DSSLC.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	All persons identified as requiring PNM supports were provided with a Physical and Nutritional Management Plan (PNMP); however, the plans were not comprehensive as they did not contain information regarding oral care and medication administration and specifics regarding head of bed elevation. Based on a review of 32 individual PNMPs (sample #1, #2, and #3), individuals were not provided with a comprehensive PNMP. • In zero of 32 PNMPs reviewed (0%), strategies for oral hygiene were included. • Thirty-two of 32 PNMPs (100%)indicated the need for increased head of bed elevation but lacked detail regarding the degree in which the person should be elevated. • In zero of 32 PNMPs reviewed (0%), PNM triggers to be observed and reported were listed as part of the plan. Including the degree of head of bed elevation is important as it allows the information regarding head of bed elevation to be easily transferrable to an off grounds location such as a hospital or a more integrated living environment. Currently, the PNMP states only that the head of bed is elevated and staff relies on chains or tape attached to the bed. This is an area that DSSLC is aware of and was in the process of providing specifics regarding HOB elevation to the PNMPs.	Noncompliance

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		Oral Care and Medication Administration were included in the PNMP but lacked detail regarding number and size 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. • In 32 of 32 PNMPs (100%) reviewed, positioning instructions for wheelchair and alternate positions instructions were included as applicable. • In 32 of 32 PNMPs (100%) reviewed, transfer instructions were included as applicable. • In 32 of 32 PNMPs (100%) reviewed, the mealtime/dining plan included intake information for mealtime and snacks • In 32 of 32 PNMPs (100%) reviewed, the mealtime/dining plan included food/fluid textures as applicable. • In 32 of 32 PNMPs (100%) reviewed, the mealtime/dining plan included behavioral concerns related to intake. • In 32 of 32 PNMPs (100%) reviewed, individual adaptive equipment was included. • In 32 of 32 PNMPs (100%) reviewed bathing/showering positioning and instructions were included • In 32 of 32 PNMPs (100%) reviewed, strategies for medication administration were included. Based on a review of an identified sample of 32 individual records (Samples #1, #2, and #3) PNMPs and dining plans were not formally developed with input from the PST. In zero of 32 records reviewed (0%), PNMPs were clearly developed with input from the PST with an emphasis on DCPs, medical/nursing staff, and behavioral staff (if appropriate). Per record review, there was evidence in the PSPs that the PNMPs were included, but there was no evidence of discussion or input from other team members. PNMPS were not reviewed by the PST and were not consistently updated in a timely manner by Habilitation Therapies as indicated by a change in the person's status. In one of five records reviewed (20%) (Sample #4), PNMPs were revised in a timely manner as indicated by a change in the individual's status. Examples of PNMPs not revised in a timely manner included: • Individual #59 had a diet upgrade recommended via MBSS on 6/28/2011 but the PNMP was not revised. • Individual #270 had a diet texture change recommended via MBSS on 5/4/2011 but the implications of the change (i.e., difficulty spoon feeding with honey consistency) was not identified until two months later.	

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		Failure to update PNMPs in a timely manner result in an increased risk to the individual as staff will not be appropriately updated regarding the needed interventions.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	PNMPs and Dining Plans were generally developed by the therapy clinicians with limited input by other PST members as described above. Generally, the PNMP was located in the individual notebook that followed the person, however individuals not residing on Houston Park or Cedar Falls did not have their books follow them and therefore the PNMPs were not readily available to staff. At no time during any of the observations was staff observed referring to the PNMPs. Staff did not consistently implement interventions and recommendations outlined in the PNMP and/or Dining Plan. Mealtime observations demonstrated that staff failed to implement 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 two of 11 (18%) observations, staff were following mealtime plans. • In six of 11 (54%) observations staff were following positioning instructions. Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan included: • Individual #432 was observed eating with his knees up against his chest resulting in increased abdominal compression thus increasing the risk of reflux/emesis. • Individuals #153, #295, #689, and #747 were observed taking large bites and eating at unsafe rates when the plans called for small bites and slow intake. • Individuals #487, #692 and #731 were observed hyperextending their necks thus resulting in an increased risk of aspiration during intake. • Individual #372 was observed eating at an unsafe rate and hyper-extending his neck when drinking from his cut out glass • Individual #545 was observed using incorrect adaptive equipment and was provided a full cup of liquids when the plan called for only a ¼ cup due to his risk of aspiration. • General safe mealtime practices such as providing liquids during the meal were also not observed Additionally, coughing and gagging was noted to occur multiple times with little to no staff awareness or intervention until notified by the Monitoring Team.	Noncompliance

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		General Observations demonstrated that staff failed to implement interventions and recommendations outlined in the PNMP which were most likely to mitigate the risk of reflux and/or aspiration: For example: • Individual #409 was observed slumped in his recliner and leaning to his right with no pillows under his legs. • Individual #574 was observed slid down in the recliner resulting in increased abdominal compression during tube feeding. • Individual #466 was observed slid down in bed and in the fetal position resulting in increased abdominal compression thus increasing the risk of reflux aspiration. • Individual #66 was observed slid down in bed and with inadequate supports between his legs resulting in an increased risk of reflux aspiration and poor contracture management. The previous compliance visit noted 33% implementation while this visit noted an 18% implementation rate. This represented a decrease in the overall implementation of PNMPs and dining plans. Staff did not understand rationale of recommendations and interventions as evidenced by not verbalizing reasons for strategies outlined in the PNMP. Lack of understanding regarding why an intervention was important contributes to a lack of urgency regarding implementation. Based on interviews with seven DCPs: • In five of seven (71%) interviews with staff, they were able to identify the location of the PNMP and/or mealtime plan. • In three of seven (42%) interviews with staff, staff could describe individual-specific PNMP strategies. • In three of seven (42%) interviews with staff, staff could describe the schedule for implementation of PNMP strategies. • In three of seven (42%) interviews with staff, staff stated they had received individual-specific training for PNMP strategies. Examples when direct support professionals were not able to describe the following PNMP indicators included: • Staff were not able to explain why it is important to alternate liquids and solids. • 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	

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		and nutritional management plans or dining plans. If staff are unaware of these, they may not observe for and report related health concerns or ensure their actions do not contribute to these risks. Overall, there was no improvement in staff knowledge regarding specific plans or the implementation of these plans since the previous visit.	
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 Habilitation Services director, 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 that have successfully completed competency-based training specific to the individual. Per interview with Habilitation Services director, core/foundational training will be provided at least annually and as indicated by monitoring but the process was just starting to be put in place.	Noncompliance

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O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	A policy/protocol that addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted did not exist at DSSLC; however, the draft policy that was in the process of being developed will outline the monitoring process. Based on review of the Facility's monitoring practices, a comprehensive PNM monitoring form was in place that was designed to address mealtime as well as areas outside of mealtime. While the form was 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, • Monitors are re-validated on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor, and • Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or 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, who had been monitored, as well as data aggregated by areas addressed by the PNM monitoring form. Per review of the monitoring list, only 5 (0.13%) of the 372 monitoring forms completed addressed oral care or medication administration. This ratio does not support a comprehensive view of how the PNM supports are effective or if they are being implemented in all areas in which the individual was at risk. In addition, the monitoring list provided by DSSLC only focused on the Houston Park living areas and did not address all the other homes on campus. There was not a formal process in place that ensured individuals with increased PNM issues were provided with increased monitoring. At the time of the review, this process was informal and directed by the attending clinician. Per review of the draft PNM policy, this is an area that should be addressed by the next compliance visit. The risk process did include a monitoring component where the PST determined through an action plan if increased monitoring was needed but the process was informal and did not contain clear directives on what areas would be monitored. Due to this informality, it	Noncompliance

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		was unclear as to who was responsible for what monitoring area (i.e., meal, bathing, snack, oral care).	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	Based on the review of 32 individual records (Sample #1, #2, and #3), 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. While PNMPs were 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). Individuals with PNMPs were reviewed on an annual basis with changes in the interim generally indicated based on referral or the identification of a problem. The clinicians did not routinely conduct proactive review of the plans with frequency based on health risk level. All members of the PNM team did not conduct monitoring. There was no system of routine review established to be conducted by the clinicians relative to the health status of those individuals at high risk who were followed by the PNMT. Per review of the monitoring list, of 372 monitoring forms were completed over the past quarter, nine (.2%) were completed by someone other than the PNMP Coordinator. There was no formal and consistent review of the PNMPs relative to how well the plan addressed or minimized these concerns. Even during the annual assessments, the plans were reviewed in a more rote manner to continue a strategy with no clear review to measure or evaluate the actual efficacy of the plan. For example, there was no review that determined if a strategy to address falls or speed of intake for an individual effectively resulted in a reduction from the previous period. There was no detailed comparative analysis of data or assessment findings. The Aspiration Trigger Data Sheet was implemented for the individuals who were on the target list, which consisted of individuals who had an aspiration event in the past two years or who were enterally fed. 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 a positive step forward in better being able to identify signs and symptoms. The issue with the existing Data sheet included:	Noncompliance

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		• 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. • Lack of consistent and detailed documentation surrounding the occurrence of triggers (e.g., activity in which trigger occurred, positioning of the individual) • Lack of consistent completion by staff (missing data points) • Lack of implementation for all individuals who were identified as being "high risk" • Trigger sheets contain information that was not relevant to the individuals (i.e., an individual who eats by mouth had a trigger that states to watch for formula in the mouth). DSSLC was aware of the lack of individualized triggers and how some triggers were not appropriate for the individual, but the concern was that staff continued to mark data points and, per interview, did not appear aware that the trigger was not relevant to the individual.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	The following section was based on a sample gathered from individuals who received enteral nutrition (Sample 3). Ten of these individuals had been included in the sample reviewed by the Monitoring Team. There were approximately 102 individuals listed as receiving enteral nutrition. All individuals who received non-oral intake (NPO) in the selected sample had been provided a PNMP that included the same elements described above. One aspect of the At Risk Individuals policy, implemented as of 1/1/11, was an outline for an Aspiration Pneumonia/Enteral Nutrition Evaluation. This form was to be used for all individuals who were at high risk for aspiration pneumonia or who were hospitalized for aspiration pneumonia multiple times within the last year, as well as a means to conduct an annual assessment of individuals who received enteral nutrition. The assessment was to be compiled by the nurse case manager based on information provided by the PCP, nursing, Habilitation therapists, dietitian, pharmacist, and other members of the PST Based on the sample of ten individuals (sample 3), five of ten (50%) individuals had received the interdisciplinary enteral nutrition assessment provided by the State. Out of the five aspiration/enteral evaluation noted in the records, one of five evaluations (20%) was fully completed. Issues missing from the evaluations included action plans, pharmacy review, and pathway to oral intake.	Noncompliance

#	Provision	Assessment of Status	Compliance
		All ten individuals had received a Habilitation Therapy assessment but content within these assessments was inconsistent and variable between therapists. While some assessments included why the tube was medically necessary, none of the assessments for those individuals who were NPO identified a clear pathway to oral intake or comprehensively addressed the oral motor status of the individuals. Attempts for oral intake focused solely on intake and did not address the swallowing components that are needed to safely tolerate intake. In other words, just because an individual fails a trial of oral intake does not mean that there are not other strategies to implement to work towards the end goal of resumed oral status. Based upon review, individual trials of intake were the only method attempted by DSSLC to increase oral intake. While transitioning from NPO status to Oral status is possible and appropriate for some individuals, there are many steps in between that are available to focus on. Included in this is oral motor strengthening or skills acquisition training related to mealtime intake. The need for continued enteral nutrition was not integrated into the PSP. Based on a review of ten individuals' PSPs, for zero of ten (0 %) (Sample #3) who received enteral nutrition, the individual's PSP clearly documented the rationale for the continued need for enteral nutrition. An example of an individual PSP that did not document the rationale for the continued need for enteral nutrition was that Individual # 497's PSP simply stated that nutrition is provided enterally. Examples of individuals who received enteral nutrition and did not receive a comprehensive annual assessment focused on pathways to oral intake: • Individuals #352, #460, and #497. Ten of ten individuals who received enteral nutrition and/or therapeutic/pleasure feedings were provided with a PNMP; however, none of these PNMPs was comprehensive and all were 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. Integrate into the PNMT process a method for data analyses and review (Provision O.1)
2. Bathing equipment should be explored to allow for the individuals to have more safe options. Devices such as shower trolley, shower chairs, and submersible tubs should be investigated. (Provision O.2).
3. The PST must meet in a timely manner in response to changes in status. This meeting should provide comprehensive problem solving and timely

implementation. (Provision O.3)

4. Medication administration, Oral Care, and Head of Bed elevation should be expanded to include information regarding number of pills the individual can tolerate at a time, strategies to assist with oral care, and degree level of head of bed elevation.
5. Aspiration Pneumonia/Enteral Nutrition Evaluation 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 (Provision O.3).
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)(Provision O.5).
7. A formal process should be developed that ensures individuals who are at an increased risk receive more intensive monitoring. (Provision O.7)
8. 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 (Provision 0.7)
9. Aspiration Trigger Data Sheet should be expanded for all individuals who are at a high risk and not just the individuals who are on the target list (Provision O.7).
10. Aspiration Trigger Data Sheet should be modified to include triggers specific to the individual (Provision O.7).
11. As was recommended in the previous compliance report, a Facility policy should be developed to ensure a system is in place to monitor staff implementation of PNMT Action Plans and PNMPs, including dining plans. At a minimum, such a policy should include
    a. Definition of a monitoring process to cover staff providing care in all aspects in which an individual is determined to be at risk (i.e., bathing, toothbrushing, personal care, alternate positioning, wheelchair positioning, medication administration, etc.);
    b. A requirement that all monitoring forms provide instructions for individual monitoring indicators to support consistency in monitoring and inter-rater reliability;
    c. Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;
    d. Formal schedule for monitoring to occur;
    e. Individuals at highest risk to be monitored at greater frequency to minimize and/or reduce identified risk factors;
    f. Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues;
    g. Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and
    h. Establishment of thresholds for staff re-training. (Provision O.7)
12. 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 (Provision O.8)

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

1. Consider an increase in nutritional staff. Three dietitians for the Facility were insufficient to adequately meet the needs of all individuals living at DSSLC (518 individuals). Increase in nutritional staff will assist the facility in better assessing individuals who are at an increased risk of aspiration and who receive not only enteral nutrition but oral intake as well.
2. DSSLC would benefit from consolidating many of their forms into one flow sheet. For example, consolidating the weight tracking logs, BM, Intake-Output, Aspiration Trigger Sheet, and Emesis log would not only make it easier to review but also facilitate improved analysis of symptoms.

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), dated 9/7/2011 2. Record Reviews: • Sample 1: Individuals #3, #20, #117, #211, #291, #336, #366, #504, #511, #519, #551 and #599 • Sample #5: Individuals #141, #172, #194, #276, #306, #415, #517, #605, #669, #690, and #697 • Sample #6: Individual #551 • Sample #7: Individuals #87, #141, #209, #221, #297, #461, #578, #580, #664, #761 and #781 3. Current Lists of people: (a) Who use wheelchair as primary mobility; (b) With transport wheelchairs; (c) With other ambulation assistive devices, including the name of the device; (d) With orthotics and/or braces; (e) Who have had a decubitus/pressure ulcer during the past year, including name of individual, date of onset, stage, location, and date of resolution; (f) Who have experienced a falling incident during the past three (6) months, including name of individual, date, location, whether there was injury, and, if so, type of injury 4. OT/PT assessments template 5. Wheelchair seating, PNM clinic assessment templates and related documentation OT/PT-related spreadsheets. 6. For the past 6 months, any summary reports or analyses of monitoring results related to OT/PT generated by the Facility, including but not limited to quality assurance reports, including action plans. 7. List of individuals receiving direct OT and/or PT services and focus of intervention **People Interviewed:** 1. Donna Groves OTR Director of Habilitation Services 2. Seven DCPs (4 Cedar Falls and 3 Houston Park) **Meeting Attended/Observations:** 1. PNMT meeting 9-19-11 2. At Risk Meeting (Individuals #306 and #42) 3. Mealtime and Transition Observations (Cedar Falls, Houston Park, Westridge, Timberhill and Eastfield)
	Facility Self-Assessment: The DSSLCC Plan of Improvement provided comments/status for Sections P.1 through P.4 of the Settlement Agreement. The Facility indicated it was in noncompliance with all provisions. The findings of DSSLC were consistent with the Monitoring Team's findings as all provisions were found to be noncompliant.

	The POI also provided a summary of some of the action plans on which the Facility was working to achieve compliance. The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the four provisions but did not provide a clear sequential framework in which they expected to reach compliance. Much work has been noted yet the current POI format appeared to merely document completion of tasks rather than serve as a well outlined plan to direct focus, work products, and effort by staff. Action steps should be stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps. The majority of statements present focused on general status and activities; however some data were provided that was gathered from the completion of the SA monitoring assessment and observations. DSSLC used these data to assist them in determining if gains were being made as a result of their efforts. Noted through the review of the completed SA assessment was consistent documentation that areas listed in the tool were present at DSSLC, however, there was no evidence paired with these responses that substantiated such claim. Additionally, the high level of scoring on the SA tool did not appear to translate over to the determination of DSSLC to be in compliance with any of the provisions.
	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 nor were they comprehensive as they lacked objective measurements and detailed information that allowed for comparative annual analysis. **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. Additionally, therapy services were not consistently integrated into the PSP. **Provision P.3:** This provision was determined to be not in compliance. Plans were not implemented as written and staff were not knowledgeable of the OT/PT plans. **Provision P.4:** This provision was determined to be not in compliance. A system did not exist that ensures staff responsible for positioning and transferring high risk individuals receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff. Based on review of the State and/or Facility's policy, a system was not in place to monitor staff implementation of PNMPs and other OT/PT interventions which included: o Definition of monitoring process o Identifies monitors (licensed professional for OT/PT intervention plans) and their roles and responsibilities o Formal schedule for monitoring to occur o Monitors are re-validated on an annual basis by therapists and/or assistants

	o Results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor As with PNM concerns, there was a lack of problem solving and identification of issues that contributed to decline. Updates focused primarily on observations and did not include objective testing to clearly identify the cause of decline. A positive note was that DSSLC was in the process of looking at bathing systems (shower chairs, trolleys and submersible tubs) in an effort to expand options for individuals who require more intensive interventions during this activity. Other positives included: • Assessments/screenings were completed within 30 days of admission for those individuals who were newly admitted. • All individuals had received an OT/PT assessment that indicated whether or not the individual required OT/PT supports and services. This high percentage was consistent with the previous compliance

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	The Facility provided an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience. There were nine Occupational Therapists (OT), nine Certified Occupational Therapy Assistants (COTA), five Physical Therapists (PT) and one Physical Therapy Assistant (PTA) Student. There are openings for one OT and one PT. With the current staffing, ratios for Occupational Therapy were 1:57 and PTs 1:103. Full staffing would be adequate to address standard OT/PT practices in addition to the increased demand of physical and nutritional supports. Clinicians were responsible for the annual assessments or updates, providing supports and services as needed, reviewing and updating the PNMP, and responding to any additional needs as they came up for each individual on their caseload, with additional supports available from the therapy assistants. Annual assessments/updates were completed by OT and PT collaboratively. Some of those who did not have established PNM needs would likely require occasional supports to address acute injuries or to address more chronic conditions associated with aging. Many others would likely benefit from skill acquisition/enhancement programs related to movement and mobility, as well as fine motor skills and independence. This level of supports and services could be adequately met with all OT and PT positions filled.	Noncompliance

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		Sample #6 consisted of the one individual who was newly admitted since the previous compliance visit. Sample #7 was gathered by requesting the top ten individuals who experienced the highest number of falls over the past 6 months. Assessments/screenings were completed within 30 days of admission for those individuals who were newly admitted. 100% of individuals (sample #6) (new admissions) had received an OT/PT assessment. Assessments indicated whether or not the individual required OT/PT supports and services for 35 of 35 (100%) (Sample #1, #5, #6, and #7) records reviewed. The OT/PT assessment addressed movement, mobility, and range of motion but, as stated in Section O, the area lacking in the OT/PT assessment remained the oral motor section. There remained a lack of objective measurable data as well as explanation of how these deficits are functionally affecting the individual. Additional concerns noted in the assessment reports reviewed included: • There was no discussion of potential for skill acquisition in areas such as eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning. • In many cases, clinical information was merely reported, but was not utilized to guide decisions regarding intervention. • In the cases in which therapy supports had been provided, there was no assessment as to the effectiveness of the interventions. • There was no comparative analysis of health and functional status from the previous year. • There was no analysis of findings that was based on the data reported and compared to a previous comprehensive assessment or update, or that provided a rationale for the recommendations for interventions and supports. • Specific health risk ratings established by the PST were not identified, and interventions, primarily the PNMP, were not specifically linked to these ratings. A new format was in draft status for OT/PT updates that were based more on the risk factors related to OT/PT (i.e., weight, falls, aspiration, and choking). The concern with the new format was that it focused more on summary of current status and description of supports and did not provide comparative analysis from the previous year's status.	

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		The individuals for sample #5 were chosen by choosing every third individual listed on the High risk for falls list. Zero of the 35 (0%) assessments (Sample #1, #5, #6, and #7) reviewed contained medical issues and health risk indicators and provided information regarding how the risk or medical condition contributed to the overall plan of care. Examples of assessments that did not provide an appropriate rationale included: • Individuals #141 and #551's OT/PT assessment contained a diagnosis list but did not provide information or links to how these diagnoses impacted the level of care. Evidence of communication and or collaboration was present in the OT/PT assessments. Based on review of 35 OT/PT assessments (Samples #1, #5, #6 and #7), 100% included signatures and date of both OT and PT. Based on review of individuals with changes in status (sample #1 and #7), there was not a consistent assessment or review as indicated by a change in the individual's status or as dictated by monitoring results. • Individual #117 had a choking event on 8-15-11. On 8-16-11, the OT conducted an observation but there was no evidence of a tableside swallowing assessment. Additionally, the OT stated that findings and recommendations would follow but there was no evidence that this occurred. • Individual #519 was diagnosed with aspiration pneumonia on 4/11/11 but there was no evidence of comprehensive reassessment upon return from the hospital. There was evidence of the PST meeting to discuss the event but the discussion was limited to the need to defer programming and did not focus on potential indicators or triggers that led to the aspiration event. • Individual #211 was diagnosed with aspiration pneumonia on 6/6/11 but there was no evidence of comprehensive reassessment upon return from the hospital. The PST met on 6/11/11 and decided to defer programming until return from hospital. The team also stated that they would meet upon return from the hospital but there was no evidence that this occurred. • Individuals #209 and #578 experienced an increase in falls over the past six months but there was no evidence of formal reassessment of gait and/or PST discussion of environmental f actors that may contribute to or decrease the risk of future falls. • Individual #172 had an increase in falls over the course of two months. The PT consult stated that an extensive assessment was provided but there was only evidence of an observation that occurred over multiple weeks. • As noted in Provision L.1, Individual #383's OT/PT assessment did not include	

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		a comprehensive assessment for the individual's OT/PT needs.	
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 22 individuals (sample #1, #5, and #6) 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. Please refer to Provisions O.2 and P.1 regarding assessments in response to a change in status. Intervention plans related to positioning, oral care, and medication administration was not based on objective findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies. For example: • Individuals #519, #336, and #690's PNMP stated to have the head of bed (HOB) elevated but there was no assessment present that justified why the assigned degree of elevation was the most appropriate. The issue regarding HOB elevation as well as bathing positioning was a systemic and pervasive issue. The assessment developed by central office regarding HOB elevation had not been implemented as of this review. Failure to provide adequate assessment regarding HOB elevation as well as bathing positioning places the individual at an increased risk of aspiration secondary to reflux. An example is Individual #252 who has poor postural tone and had a difficult time maintaining the 30 degree elevation which resulted in the individual sliding down in bed thus increasing the risk of aspiration. A positive note was that DSSLC was in the process of looking at bathing systems (shower chairs, trolleys etc...) in an effort to expand options for individuals who require more intensive interventions during this activity. Based on reviews of PNMPs for 35 individuals (sample #1, #5, #6, and #7), equipment was specified for 22 of 22 (100%) plans reviewed. Within 30 days of the annual PSP, or sooner as required for health or safety, a plan was developed as part of the PSP but was not consistently reviewed by the PST. Plans were generally limited to the PNMP that was reviewed at the time of the annual PSP and were generally updated as needed due to a change in status. The main issue was that there was no evidence that the majority of plans were reviewed by the PST related to program changes or changes in status. Please refer to Provision O.3 for more information.	Noncompliance

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		Other than direct therapy services, the primary support provided was via the PNMPs. PNMPs addressed areas related to positioning, transfers, handling, and mobility, but interventions were limited when related to promoting independence and skill acquisition; interventions did not focus on skills acquisition or independence. PT intervention was generally designed to address gait and ambulation. OT intervention was focused mostly on range of motion and strength training. The interventions in place were well documented and had established measurable and functional goals. Justification for continued therapy or discharge was well documented in the progress notes. Programs and interventions for other skill acquisition were not identified as a need and, as such, were not provided. The PNMP addressed use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used but lacked the specificity needed to ensure safe oral care and medication administration. Please refer to Provision O.3 for additional information.	
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.	A s mentioned in Provision O.5, training curricula revealed 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. There was not a clear process that ensured pulled staff was provided with individualized training prior to working with individuals who were identified as being at an increased risk of aspiration. Based on interviews of direct support staff, staff did not understand the rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the OT/PT plans and /or PNMPs. Lack of understanding regarding why an intervention was important contributes to a lack of urgency regarding implementation. Based on interviews with direct support professionals: • In five of seven (71%) interviews with staff, staff were able to identify the location of OT/PT plans.	Noncompliance

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		• In two of seven (28%) interviews with staff, staff could describe individual-specific OT/PT strategies. • In one of seven (14%) interviews with staff, staff could describe the schedule for implementation of OT/PT strategies. • In five of seven (71%) interviews with staff, staff stated they had received individual-specific training for OT/PT strategies. Examples of direct care professionals who were not able to describe the rationale for OT/PT interventions and recommendations: • DCP on Cedar Falls was not able to describe why individuals used modified dining equipment. • DCP on Houston Park and Cedar Falls was not able to describe rationale for maintaining appropriate elevation.	
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 has 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 formal 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 (Refer to Section O-5). A policy/protocol addressing the monitoring process did not exist and did not provide a clear direction regarding its implementation and action steps did not exist at this time at DSSLC. Based on review of the State and/or Facility's policy, a system was not in place to monitor staff implementation of PNMPs and other OT/PT interventions which included: o Definition of monitoring process o Identifies monitors (licensed professional for OT/PT intervention plans) and their roles and responsibilities o Formal schedule for monitoring to occur o Re-evaluation of monitors on an annual basis by therapists and/or assistants o Results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor Responses to monitoring findings were not clearly documented from identification to	Noncompliance

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		resolution of any issues identified. There was documentation noted directly on the monitoring form but there was no data system to collect and aggregate data obtained from the completion of the monitoring forms; such a system would be useful in identifying areas needing attention (including specific services needing improvement and specific houses and activity programs needing improved performance). Also, development if such a data system would allow DSSLC to direct services at locales and activities in which they were most needed.	

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

1. The assessment format should contain oral care and medication administration as well as information and assessment in these areas. The format should contain objective assessment findings and not just state a recommendation. Additionally, the areas of activity tolerance, ADLS, and balance should be addressed consistently and in a comprehensive manner. Information should be measurable to allow for comparative analysis from year to year. If there are strategies listed on the PNMP then there should be an assessment indicating why the strategies listed were appropriate and the method for determining these strategies. (Provision P.1).
2. After a fall, clinical staff should evaluate extrinsic factors (e.g., wet floor, loose rug); intrinsic factors (e.g., seizure disorder); and medications. A thorough assessment of gait and balance should be included as part of the assessment. Further, the appropriateness of mobility devices, such as walkers and wheelchairs, and the need for personal assistance should be reviewed regularly and re-evaluated as necessary (Provision P.1).
3. Programs to address weakness or instability with gait should be expanded as part of the overall plan of care (Provision P.2).
4. Current therapy services being provided to individuals should be integrated into PSP skill acquisition programs to provide multiple opportunities for incidental teaching, formally and informally (Provision P.2).
5. The frequency of PNMP monitoring needs to be driven by risk level; those at highest risk must be monitored with sufficient frequency to ensure adequacy and efficacy of the supports provided as well as the accuracy of staff implementation of these supports (Provision P.4).
6. Restorative and maintenance programs should be developed by OT/PT to prevent decline in ambulation and overall functioning (Provision P.2).
7. Policies/procedures should be developed for the OT/PT monitoring system, with identified performance indicators that are defined clearly. This system should include, but not be limited to, a systematic and routine review of the components of PNMPs and related equipment, and OT/PT instructional/intervention programs and equipment; staff utilization of the equipment; fit, function, availability, and use of adaptive equipment; and staff competency with PNMPs, therapy instructional/intervention plans, as well as activity plans. There should be established thresholds for staff re-training; identification, training, and validation process for monitors to achieve accurate scoring; and inter-rater reliability methodologies (Provision P.3 and P.4).

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. DSSLC Plan of Improvement 9/7/11 2. DSSLC Dental Emergencies Procedure, DS-16, dated 8/1/11 3. DSS:C Dental Clinic Operations, DS-14, dated 8/1/11 4. Section Q compliance data for March through June, 2011 5. Oral Hygiene data for May, June and July, 2011 6. Overall Facility Good Oral Hygiene data for May through August, 2011 7. Memo to the Facility Director from the Dental Office on oral hygiene levels, not dated 8. Denton State Supported Living Center, Oral Hygiene Scale and training materials, undated **People Interviewed:** 1. Dr. Michael Cousins, DDS, Dental Director 2. Cynthia Murrell, Dental Hygienist **Meeting Attended/Observations:** 1. Individuals on the Cedar Falls and Timber Hill living areas were observed for oral hygiene.
	Facility Self-Assessment: The Facility reported that they remain noncompliant with Provision Q1. The Facility reported accomplishing many activities as outlined in their POI. For the most part, the POI simply reported on actions taken, rather than evaluating whether the actions taken are producing the desired outcomes, and why or why not. The POI did not provide details as to how the Facility assessed its status other than the listing of activities. The Facility provided a list of a few Action Steps but the Monitoring Team was unable to determine the Facility's overall plan for compliance. For Provision Q2, The Facility reported many completed tasks, as outlined in the POI; however, the POI did not delineate action steps necessary for compliance with Provision Q2 or indicate how it assessed its current status.
	Summary of Monitor's Assessment: Q1: The Monitoring Team noted an abundance of new policies and procedures for the delivery of dental services. The Monitoring Team was impressed with the process developed and recent outcome of improving oral hygiene at the living area. The Facility was noted to have an operational process to provide emergency dental services. The Monitoring Team was unable to determine if routine dental services were optimal because the Facility was unable to report which individuals were actually up to date with their dental health care needs and who remains deficient and for what reason they were deficient. The Monitoring Team determined that the Facility remains noncompliant with Provision Q1; the Facility will need to ensure that real time information regarding the status of dental care is available to the Facility and that individuals are receiving adequate and timely dental services, including services under appropriate oral, iv, and general anesthesia.

	Q2: The Monitoring Team concurred with the Facility self-assessment of not being in compliance with Provision Q2. Dental Services was not well integrated in the Team process, and the Facility had made little headway with developing a dental desensitization program. Compliance will require the Facility to develop a robust method to ensure that dental services are well integrated into the team process and POI and that a behavioral efforts towards desensitization programs are developed, implemented and functional.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	When providing Dental Services to individuals served, the Facility reported utilizing the American Dental Association's guideline for persons with developmental disabilities. The Facility maintained a mechanism to provide emergency dental services to individuals served. In the event of a dental emergency that occurs after hours, the Individual will be assessed by the on-call physician, who will then either provide palliative treatment and refer the individual to the Facility's dentist on the next business day, or if clinically indicated will triage the individual to the local Emergency Department. The Dental Services Procedure, DS-16, dated 8/1/11, was updated to reflect this process. Routine dental service was provided on-site. At the time of this review, the Facility had hired a second dentist to provide direct dental care, along with Dr. Cousins, who also serves as the Director of Dental Services. The Facility had two dental hygienists and two dental assistants, who in addition to providing assistance with dental cases also provided clerical support for the dental office. During the on-site review, the Monitoring Team experienced challenges when attempting to quantitate the number of individuals who were up to date with their dental health care and those of who are not up to date. The Facility could not provide an absolute quantitative number of individuals who are delinquent with dental oral health care. At the time of the review, Dr. Cousins reported that a total of 43 people were on the list for intravenous sedation for dental procedures. The Monitoring Team raised concern over such low number, and requested a list of all individuals who require i.v. sedation. The list included a total of 158 Individual who require i.v. sedation. Dr. Cousins reported that the Facility could support a total of 240 appointments, which is inadequate to provide necessary dental assessments, hygiene, and restorative treatment for all individuals at the Facility requiring i.v. sedation. Dr. Cousins reported that the Facility needed an additional two days for i.v. sedation per month, to fully accommodate individuals served. Dr. Cousins could not quantitate the number of individuals who could benefit by oral	Noncompliance

#	Provision	Assessment of Status	Compliance
		sedation, anxiolysis, and/or physical and behavioral support for dental procedures. The exact number of individuals who are completely current with their dental care, and those who are deficient because of inadequate opportunities for i.v. sedation, oral sedation and/or physical and behavioral supports remained unclear to the Monitoring Team. The Facility could not provide this information at the time of the review. The Facility offered general anesthesia for dental procedures through an arrangement with the local hospital. The Monitoring Team requested a hard copy list of individuals who require general anesthesia; however, this was not provided. The Facility reported that no individuals required general anesthesia. The Monitoring Team raised concerns over the extreme number of pneumonia cases at the Facility, and asked if there was a process where by the dental office does retrospective reviews to assess for possible aspiration pneumonia following dental procedure. Dr. Cousins reported that they do assess for adverse outcomes; however, there is no formal process by the dental office to collect quality assurance data on adverse outcomes following dental procedures. Dr. Cousins was unable to provide the Monitoring Team with the exact number of individuals at the Facility who required suction toothbrushing. Dr. Cousins did, however, report that for the two homes that had been reviewed, those requiring suction toothbrushing were receiving such treatment. The Monitoring Team was provided a list of individuals at the Facility who currently are receiving suction toothbrusheing and a list of 16 Individuals who are at high risk for aspiration and are not using suction toothbrushes. The Monitoring Team concluded that the Dental Office had yet to fully identify all individuals at the Facility who require suction toothbrushing and had not implemented a suction toothbrushing program for those in need. This is of significant concerns to the Monitoring Team, because of the number of cases of aspiration pneumonia and deaths related to aspiration at the Facility. The Dental Office reported obtaining dental x-rays every one to two years for surveillance purposes. Individuals who are totally edentulous are provided x-rays every five years. The Facility had a robust process to help improve oral hygiene at the living areas. The Monitoring Team observed Individuals on Timber Hill and Cedar Falls living areas and noted that oral hygiene was provided to individuals. This was in stark contrast to previous reviews. The Dentist and Hygienist frequent the living areas and work with staff to ensure that oral hygiene is adequately provided. The Facility maintains a specific database on oral hygiene. At the time of this review, the Facility's oral hygiene data	

#	Provision	Assessment of Status	Compliance
		indicated that 48% of the individuals required improvements with their oral hygiene, compared to 60% the previous month. It is important to note that individuals were still reported to have undisturbed plaque when seen by the dental office. Undisturbed plaque is an absolute indicator that oral hygiene was not provided to the individual for a substantial amount of time. Nevertheless, initiation of this new process and the initial outcomes suggest the Facility, and staff who assist with enhancing oral hygiene at the living area, should be complimented for their diligence and work on this important issue. The Monitoring Team recognized improvements in the provision of oral hygiene at the living area and that a standard of care process is in place for dental emergencies, and that dental professionals rely on the American Dental Association's guideline for persons with developmental disabilities, when providing dental services. The Monitoring Team has significant concerns about the dental office's inability to provide readily available, and definitive information of individuals who are deficient with their dental health care needs, and lack of definitive information regarding adverse outcomes following dental treatments, such as cases of aspiration. Also of concern is the lack of assessing all individuals for suction toothbrushes, and not providing suction toothbrushing to individuals known to be at risk for aspiration. For these reasons, the Facility is non-compliant with Provision Q.1, of the Settlement Agreement.	
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'	As outlined in Provision Q.1, of this report, the Monitoring Team experienced challenges when attempting to quantitate the number of Individuals who are either up to date, with there dental health care and those of who are not up to date. The Facility could not provide an absolute quantitative number of Individual who are delinquent with dental oral health care, hence, the Monitoring Team could not determine if dental services was provided timely. The POI and Dr. Cousins reported that the dentist attends annual Personal Support Plan meeting for individuals with poor oral hygiene and provides a dental summary to assist the team with necessary supports and interventions needed. Following review of the clinical records of Individuals #83, #310, #4, and #690, the Monitoring Team could not identify an updated dental summary, nor did the Annual PSP reflect specific supports and services needed for dental services. Importantly, following attendance at a community living discharge plan meeting for Individual #384, dental issues were not discussed with the accepting agency, and the PST was confused as to what supports were necessary for dental services. The Dental Office had identified this individual, as requiring sedation for much needed dental services; however, the PST was unaware of that issue. Dr. Cousins reported that the Psychology Department has recently hired staff to help with developing programs to minimize use of pre-treatment sedation and restraints and	Noncompliance

#	Provision	Assessment of Status	Compliance
	refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	to develop strategies to overcome refusals to participate, and that a new desensitization process will be implemented in the near future. Dr. Cousins reported that if an Individual misses three or more dental appointments, the dentist will attempt to go to the PSP; however, Dr. Cousins could not provide definitive information with regards to individuals who have missed more then three appointments and his attendance at such PSPs. Dr. Cousins conceded that he is unable to attend all such meetings. Of the five individuals reviewed by the Monitoring Team, (Individuals #83, #310, #4, 384, and #690), there was no mention in the PSP of desensitization efforts or comments on efforts to overcome individual's refusals to participate in dental appointments. The use of sedation for dental services will is reviewed is Provision J, of this report. Given its findings that there is a systemic lack of integration of health care issues in the PSP, and because definitive information regarding delinquent dental services cannot be provided to the Monitoring Team, the Facility remains not in compliance with Provision Q.2, of the Settlement Agreement.	

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

1. The Dental Office must ensure that it is aware of all individuals who are delinquent with dental treatment, including dental hygiene, along with reasons why they are delinquent, and develop a timely approach to ensure that treatment is provided
2. Suction toothbrushes must be provided to all Individuals who are at risk for aspiration, when clinically appropriate. The Facility must be maintain a process to ensure that those at risk are adequately identified.
3. The Facility must improve delivery of oral hygiene at the living area
4. The Dental Office must maintain a quality assurance process for dental services that includes monitoring for adverse reactions following dental procedures, such as aspiration pneumonia and sepsis
5. Develop a process that ensures dental services integration in the team process. The Team must be aware of supports and services necessary for dental health care needs

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), dated 9/7/2011 2. Record Reviews: a. Sample #6: Individual #551 b. Sample #8: Individuals #11, #188, #283, #362, #441, #458, #467, #571, #702, #707, #713, and #779 c. Sample #9: Individuals #172, #250, #277, and #469 3. A list of people with Alternative and Augmentative Communication (AAC) devices 4. AAC evaluation and Speech Language assessment template 5. Monitoring tools template for ACC and SLP programs 6. Revised Master Plan for Communication 7. List of individuals receiving direct speech services, and focus of intervention 8. Training Roster (last 6 months) **People Interviewed:** 1. Joy Sibley CCC-SLP Director of Communication Therapy 2. Donna Groves OTR Director of Habilitation Services 3. Life Skills Instructors (Cedar Falls) 4. Five DCPs (Houston Park, Cedar Falls and Westridge) **Meeting Attended/Observations:** 1. Cedar Falls, Houston Park, and Westridge transition times 2. Mealtimes and Transitions on Cedar Falls, Houston Park, Timberhill, Eastfield and Westridge 3. Life Skills (512 and 502)
	Facility Self-Assessment: DSSLC Plan of Improvement provided comments/status for Sections R.1 through R.4 of the Settlement Agreement. The Facility indicated it was in noncompliance with all provisions. The findings of DSSLC were consistent with the Monitoring Team's findings as all provisions were found to be noncompliant. The POI also provided a summary of some of the action plans on which the Facility was working to achieve compliance. The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the four provisions but did not provide a clear sequential framework in which they expected to reach compliance. This approach appeared to document completion of tasks rather than serve as a plan to direct focus, work products, and effort by staff. Action steps should be stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps. DSSLC had stated that they had streamlined the process of acquiring speech-generating devices, and upon review of the communication list, it was noted the delay had decreased since the last compliance visit. Additionally, DSSLC had noted that the SLPs were more involved in the trainings and per review of training

	rosters, this was noted by the Monitoring Team.
	Summary of Monitor's Assessment: **Provision R.1:** This provision was determined to be not in compliance. DSSLC only had 3.5 SLPs on campus. The ratio of therapist to client was 1:172, which was too large a caseload for the therapists to actively participate in all facets of care. **Provision R.2:** This provision was determined to be not in compliance. Individuals identified as having decreased communication had not consistently been provided with the needed assessments, and assessments that were provided were not consistently comprehensive in identifying methods to expand communicative functioning. Programs in place to assist some individuals were not being consistently implemented. **Provision R.3:** This provision was determined to be not in compliance. AAC devices were not consistently portable, functional or available in a variety of settings. DCPs interviewed were not knowledgeable of the communication programs. **Provision R.4:** This provision was determined to be not in compliance. DSSLC 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 and there was not a process in place that ensured devices were meaningful or functional. Due to the lack of staff availability, progress in these areas continued to shown very slow improvement. Implementation of devices and mentoring of staff related to these devices were not occurring with enough frequency to improve the overall level of care as it related to communication expansion.

#	Provision	Assessment of Status	Compliance

R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff	The Facility did not provide an adequate number of speech language pathologists or other professionals (i.e., AT specialists) with specialized training or experience. At the time of the onsite monitoring review, SLP staffing consisted of 3.5 SLPs.
		General tasks in which Speech Pathology is responsible:
		• Attendance at:
		  • Pre-admission meetings
		  • 30 day planning conferences for all new admissions
		  • Annual planning conferences
		  • PNMT meetings
		  • PSP meetings
		• Conduct/write Communication Assessments
		• Provide direct treatment services
		• Maintain training data as applicable
			Noncompliance

#	Provision	Assessment of Status	Compliance
	training, and monitor the implementation of programs.	• Develop and implement augmentative and alternative communication devices • In-service and monitor use of the devices • Maintain contact with personnel regarding school age residents • Provide consultation, counseling and referral as needed • Provide new employee orientation • Meal Monitoring The current ratio of therapist to client ratio was 1:172. This ratio did not allow for the appropriate follow up or involvement of the SLP in all facets of the individuals care and was not conducive to enhanced participation in the individuals' communication development. At the time of the review, direct speech services were primarily limited to individuals who had AAC devices. Sample #8 was selected by choosing every tenth individual on the list provided by DSSLC as having severe expressive or receptive language disorders (Priority 1). Sample #9 consisted of choosing every fifth individual identified on the list of individuals receiving direct speech services. Nine of 17 (53%) individuals reviewed (sample #6, #8 and #9) had appropriate communication goals. Examples of goals not being written appropriately or not written at all included: • Individual #441's communication assessment recommended an AAC objective but there was no evidence that this was provided. • Individual #283's PSP stated that the individual would benefit from an AAC device to help decrease the risk of falls when the individual awakens in the middle of the night but there was no evidence that this was provided. • Individual #458's communication assessment identified multiple strategies to utilize and areas to focus on communication but there was no evidence of these strategies being developed into a meaningful goal. • Individual #11's PST requested a Speech assessment 6/2011 but there was no evidence that this was provided. Per interview with the Director of Speech and Hearing, time was primarily focused on the development and completion of assessments, and did not permit the time needed to write goals, monitor goals and ensure staff involvement with implementation of the plans. It was hoped that by revising the master communication plan, more time would be allowed to address these areas and maintain areas where some progress had	

#	Provision	Assessment of Status	Compliance
		occurred.	
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.	The communication assessments for samples #6, #8 and #9 were either not present or not comprehensive enough to allow for the identification and potential expansion of communication skills. • In zero of 17 (0%) records reviewed the assessment comprehensively addressed verbal and nonverbal skills. • In 15 of 17 (88%) records reviewed the assessment addressed whether the individual requires direct or indirect Speech Language services. While the assessments contained recommended strategies or the use of an actual device, the assessment lacked detail regarding the individual's status. For example: • Individual #362, #571 and #707 assessment's stated that gestures, facial expressions or vocalizations were used as a method of expressive language but provided no further information regarding the catalog of gestures or vocalizations utilized. For persons receiving behavioral supports or interventions, the Facility had a process designed to identify who would benefit from AAC or speech assistance. The potential for the behavior to serve as communication was included as part of the behavioral assessment and Speech assessment process and the SLP attended all Positive Behavior Support Committee meetings and provides consultations to those who are identified as having speech or language issues that may be contributing to the target behavior. Since the previous review, one individual was admitted to DSSLC. The individual's record was requested (Sample #6). This individual did not receive a communication assessment within 30 days of admission; therefore, zero of one received a Speech Language evaluation within 30 days of admission. A draft of the revised Master Plan for Communication was developed by DSSLC. Individuals were categorized according to five priority groups based on identified care codes that provided a description of the individual's communication functioning. The care codes ranged from 1 (no issues) to 4 (severe issues). As of this review, the majority of individuals identified as priority 1 had received a communication assessment within the past 6 years. The problem with the completed assessments was that many were 3-5 years old and it was unclear as to whether these assessments remained appropriate or relevant to the person today. Additionally, as stated above, the assessments were not consistently comprehensive.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Per interview with the director of Speech and language, Priority 2 individuals had not yet been provided with updated comprehensive assessments but the informal plan was to address these individuals during the upcoming year. Zero of 12 Individuals (Sample #8) who had communication devices or programs were provided with the appropriate follow up of such devices or programs. For example: • Individuals #362 and #441 had AAC objectives but there was no evidence of monthly or quarterly review by the SLP or QMRP. • Individuals #467 and #571 had AAC objectives and evidence of quarterly review; however, the quarterly review only documented the percentage and did not include any information regarding level of independence or cues provided to achieve success.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	In three of the 12 records (sample #8) reviewed (25%), goals and objectives were determined to be functional and meaningful as evidenced by the demonstration of progress and or improvement. Programs, goals and objectives related to the acquisition or improvement of speech or language were not written by the SLP. In zero of 12 records (sample#8) reviewed (0%), individuals with needs for language acquisition had goals/objectives/outcomes written and followed monthly by the SLP if service is direct and quarterly if indirect. Zero of the 12 records (sample #8) reviewed (0%) had a clear rationale and description of communication interventions integrated into the PSP. Examples of PSPs in which communication was not adequately integrated included: o Individual #707's PSP just mentioned that facial expressions were used to communicate. o Individual #702 PSP simply stated that no speech treatment was needed. PSPs at times 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. There was no evidence of detailed strategies or translation of nonverbal skills (i.e., communication dictionary) integrated into the PSP to assist staff with methods to increase communication.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The PSPs offered very limited descriptions of how an individual communicated with others**.** In most cases only recommendations from the communication assessment were identified rather than descriptions of the individual's abilities or potentials. Strategies that staff could use to enhance communication were also very limited. Some examples included: • Zero of the 12 records (sample #8) reviewed (0%) clearly identified how the individuals communicate with others and interact with their surroundings. Examples were provided in Provision R.3. • Communication information was not integrated into the daily schedule. o Zero of the 12 records (sample #8) (0%) reviewed had communication interventions and methods to improve communication integrated into the daily schedule. General AAC devices were available in the common areas of Westridge, Houston Park, and Cedar Falls. While the number of devices continued to increase, the use of the devices throughout the day had not increased. Additionally, while the devices were available, they were not readily accessible to the individuals or consistently working. For example: • The "more drink" devices were located on the wall in the dining rooms, which was inaccessible to the individuals unless they were seated next to the device. • Two of eight shared environmental control devices (25%) were functioning properly. • Six of 16 AAC shared devices (38%) were functioning properly During the observations at Cedar Falls, Houston Park, Timberhill, Eastfield and Westridge, there was no utilization of the communication boards, environmental control devices or AAC devices by the individuals nor was there encouragement to use said devices although there were multiple opportunities (such as transition times) in which the use would have been beneficial and appropriate. An example was Individual #674 who used his wheelchair to move over to the environmental control device to activate the radio but staff did not acknowledge this or assist with activation. Communication strategies/devices were not implemented and used. Four observations demonstrated that staff did not implement interventions and recommendations outlined in the Communication Assessment. Examples of individuals where staff did not implement a communication program as written included: • Individuals #11, #362, #571, and #779 were not observed using their communication devices although there were opportunities in which activation or training of a device would have been appropriate and meaningful.	

#	Provision	Assessment of Status	Compliance
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	DSSLC had a monitoring form that tracked the presence and working condition of the AAC equipment; however, implementation 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 were 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 Speech and Hearing Services, a validation/monitoring tool was in the process of being developed. This form was reviewed and discussed with the Monitoring Team. Once implemented, this tool should assist DSSLC in better identifying the efficacy of the provided communication interventions. DCPs were not knowledgeable of the communication programs as evidenced by: • In two of five interviews (40%), DCPs were able to locate adaptive equipment. • In one of five interviews with staff (20%), staff could describe individual-specific communication strategies for the individuals they served. • In four of five interviews with staff (80%), staff could describe the schedule for implementation of communication strategies. • In two of five interviews with staff (40%), staff stated they had received individual-specific training for communication strategies. Instances in which staff could not describe individuals' communication included: • Discussion with two 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. • DCPs on Westridge were unable to explain the schedule in which the shared devices would be utilized and the method for providing assistance with these devices.	Noncompliance

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

1. Many recommendations appeared to be left to the PST for the development and implementation of plans. It is critical that SLPs be involved at least in a consultative model to ensure that the plans, materials and implementation are within the scope of the individual's abilities and/or promote enhancement and skill development, as well as to provide modeling and coaching for staff. SLPs should be utilized in the development of

instructional plans in a variety of settings to ensure that they are individualized with regard to the communication strategies incorporated into these plans (Provision R.1).

2. DSSLC should focus on methods to increase staffing as it was not sufficient to meets all the needs of the individuals. This especially relates to the availability of staff to provide modeling and monitoring of goals and objectives, as well as the ordering of equipment (Provision R.1)
3. Communication Goals should be followed by the SLP at a level that allows for consistent review of progress with goals and objectives. (i.e., on a monthly basis if service is direct and quarterly if indirect). (Provision R.2)
4. Provide increased guidance for therapists completing the speech assessments thus facilitating improved consistency and comprehensiveness of assessments (Provision R.2)
5. Individual communication programs should be integrated into PSPs through skill acquisition programs, as well as PBSPs (when appropriate), to ensure the AAC device is meaningful to the individual and the individual can communicate and be an active participant in multiple environments (Provision R.3).
6. Monitoring for AAC systems should address effectiveness and implementation versus only availability and condition. This will require professional staff to conduct more frequent and thorough monitoring in addition to that conducted by the Speech Tech (Provision R.4).

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. Denton State Supported Living Center (DSSLC) Plan of Improvement (POI), /2011 2. DSSLC Presentation Book for Section S 3. Behavior Services Peer Review Committee meetings minutes (2/9/2011 – 7/27/2011) 4. Behavior Service departmental meetings minutes (3/24/2011 – 07/22/2011) 5. Preliminary materials for Competency-Based Training. 6. Documents that were reviewed included the annual PSP, PSP updates, Specific 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: #012, #035, #050, #504, #709, #119, #127, #148, #163, #168, #181, #182, #195, #217, #229, #287, #297, #306, #334, #336, #337, #349, #352, #381, #445, #482, #526, #533, #551, #585, #590, #624, #627, #703, and #778 **People Interviewed:** 1. Randy Spence, MS – Director of Behavior Services 2. Jill Wooten, MS, BCBA – Psychologist 3. Katy Acheson, MS, BCBA – Contract Psychologist 4. Brian Almejo, MS – Psychologist 5. Denney, Dale, M.Ed., LPC-S – Psychologist 6. Candy Mathers, MS – Psychologist 7. Robert Schecter, MS, LPC – Psychologist 8. Kristen Skousgard, MA, BCBA – Psychologist 9. Janet Waggoner, MS, LPC-I – Psychologist 10. Linda Ford – Director of Active Treatment 11. Approximately 30 direct care staff **Meeting Attended/Observations:** 1. At Risk Meetings (9/20/2011 and 9/22/2011) 2. Psychology/Psychiatry Meeting (9/20/2011) 3. PSP – 508 (9/21/2011) 4. PBSC (9/21/2011) 5. Restraint Reduction Committee – (9/21/2011) 6. External Peer Review (9/22/2011) 7. Human Rights Committee (9/22/2011) 8. Observed residences and classrooms on 512s (9/21/2011) 9. Observed vocational settings and classrooms (9/21/2011) 10. Observed residences on 522s (9/21/2011)

	11. Observed residences on 508s, 522s, 524s and 528s (9/22/2011)
	Facility Self-Assessment: At the time of the site visit, DSSLC reported that no Provisions of Section S were in substantial compliance with the SA. The Monitor was in agreement with the Facility in relation to this assessment of status. Although the Facility self-assessment was accurate, the Plan of Improvement was of concern to the Monitoring Team. The Facility reported that several activities related to compliance with the SA, such as use of the Murdoch materials and the provision of training to QDDPs and Active Treatment staff, were complete. It may have been accurate to state that the training class had been attended on schedule, but attendance alone was not sufficient to consider training as completed. As evidenced by a review of documents and observations in various residences, it was clearly evident that the training and active treatment preparation efforts thus far by the Facility had not been applied beyond the classroom. Based upon observations and documentation reviewed during the site visit, the Facility lacked a coherent and comprehensive approach to meeting the requirements of section S of the SA. Furthermore, the self-assessment and POI suggested that the Facility had yet to develop a clear understanding of the conceptual, technological, and applied requirements of the SA.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at DSSLC from 9/19/2011 through 9/23/2011. Record reviews continued off-site for several days following the site visit. Based upon data collected as a part of the site visit, there were no provisions of this Section found to be in substantial compliance. Although no substantial compliance was noted, the Facility had achieved progress in some areas. Many of the skill acquisition programs were found to be based upon some form of task analysis. It was also noted that training involved ample opportunities for the target behavior to occur, thereby ensuring that reinforcement and learning could occur. Skill acquisition programs also often included specific reinforcement for successful responses. In addition to improvements in skill acquisition programs, it was also noted that the Facility had provided several training classes to employees regarding the development and implementation of skill acquisition programs. Despite these areas of improvement, however, the site visit also encountered several areas in which supports and training were not adequate. Training programs often lacked the detail and specificity necessary for staff to conduct skill acquisition training consistently and competently. In addition, skill acquisition programs often required individuals to demonstrate mastery for unnecessarily long durations before the training method was revised. Of greatest concern during the site visit were the substantial lapses in the provision of active treatment and failure to intervene in order to ensure the safety of individuals living at the Facility. During several observations, it was noted by the Monitoring Team that employees of the Facility failed to intervene when

	individuals living at the Facility were engaged in potentially dangerous behavior. In addition, staff were observed failing to implement training programs or offer informal training and support when necessary. Although the progress achieved by the Facility was noteworthy, DSSLC must act diligently to meet all requirements of this Section..

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	During the current site visit, the review process consisted of a review of the records for 25 individuals, as well as observations of program implementation. 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, training methods that were too vague, and too few opportunities for learning and reinforcement. During the current site visit, skill acquisition programs for 25 individuals were reviewed. This review identified improvement in several areas of the skill acquisition programs. • A majority of the 25 programs were based upon a basic task analysis targeting the skill area to be taught. • Over three-quarters of the programs involved the presentation of discriminative stimuli or cues that training was being conducted. • Ninety-four percent of the programs reviewed included situations in which the behavior being taught was provided ample opportunity to occur. During the baseline visit, it was unclear that the target behavior or skill would occur with sufficient frequency to be reinforced. Overall, however, many of the limitations noted during the baseline visit in March 2010 continued to exist; 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	Noncompliance

#	Provision	Assessment of Status	Compliance

praise, and no strategy for generalization was identified.

Area	3/2010	9/2011	Change
Plan reflects development based upon a task analysis.	0%	57%	57%
Behavioral objective(s).	0%	40%	40%
Operational definitions of target behavior.	0%	11%	11%
Description of teaching conditions.	0%	11%	11%
Schedule of implementation comprised of sufficient trials for learning to occur.	0%	0%	0%
Relevant discriminative stimuli.	0%	77%	77%
Specific instructions.	0%	6%	6%
Opportunity for the target behavior to occur.	0%	94%	94%
Specific consequences for correct response.	100%	89%	-11%
Specific consequences for incorrect response.	0%	0%	0%
Plan for maintenance and generalization that includes assessment and measurement methodology.	0%	0%	0%

The following specific issues were noted during the review of skill acquisition programs.

Behavioral objectives and definitions. It is essential that efforts to strengthen skills include specific behaviors or skills to be increased, the level of success that the individual is expected to achieve, and the time within which that success would be achieved. In many cases, the goal for a training program consisted of only a general statement that did not clearly indicate what specific skill or behavior was to be increased. As a result, it was not evident how the objective related to the specific needs of the individual or contributed to enhancing the individual's abilities. For example, a Training Objective for Individual #337 stated only that the individual would identify community roles and services.

Description of teaching conditions. In order for teaching programs to be implemented as intended, the staff implementing those programs must be given explicit instructions including what materials to use, how those materials are to be presented, where training should be conducted and how the environment should be controlled. Without such instructions, training procedures often drift or change across staff and location. As a result, training is ineffective and can strengthen the wrong behavior. The training programs reviewed at DSSLC during the current site visit often lacked details and failed to ensure that training would be implemented consistently. For example, for Individual

#	Provision	Assessment of Status	Compliance
		#778, the teaching methodology indicated that staff were to take the individual to the store to buy a magazine, show her the magazine rack, and prompt her to choose one. These instructions did not provide staff with sufficient information about how training was to be implemented. An appropriate description could have included in which store the training would be conducted, the number of magazines to be included in the selection options, how the magazines were to be presented to the individual, the type and numbers of prompts to be used, and how long the individual was allowed to demonstrate a choice. Sufficient trials. It has been repeatedly demonstrated in research regarding learning that the development of skills requires repetition. In the majority of cases, while the skill is initially being learned, high rates of repetition are required so that the individual is provided multiple opportunities of reinforcement. Often, the lower the frequency of reinforcement opportunities, the slower the rate of learning. If the rate for reinforcement opportunities falls too low in relation to a specific behavior, that specific reinforcement may not effectively and efficiently compete with other reinforcement in the environment. In the majority of skill acquisition programs reviewed at DSSLC, the teaching trials were provided at a rate of one per day or less. Consequences for incorrect responses. The majority of training programs at DSSLC included the provision of potential reinforcement following a successful display of the target behavior. In order for training to be most effective, however, in many cases there must also be a consequence for an incorrect response that reduces the probability of future incorrect responses. For example, if attention is reinforcing for an individual and is used to reinforce successful displays of the target behavior, the consequence for an incorrect response might involve withholding attention for a few seconds (as opposed to providing more attention by correcting the response or giving a long explanation of what the individual needs to do). This serves to weaken undesired responses and strengthens the power of the reinforcement used for correct responses. None of the training programs reviewed at DSSLC included instruction to staff regarding consequences for incorrect responses. Data collection. In order to assess an individual's progress toward developing skills and behaviors, it is essential to have valid and reliable data. This in turn requires that personnel who are tasked with collecting data are provided specific and detailed instructions. In many cases, the skill acquisition programs at DSSLC did not provide adequate instructions for data collection. • For Individual #337, a skill acquisition program involved completing a task with one verbal prompt. The methodology of the program allowed for up to three verbal prompts. The data collection instructions did not include the procedure for recording multiple prompts.	

#	Provision	Assessment of Status	Compliance
		Timeframes for success. Under most circumstances, once an individual has demonstrated mastery of a task over several sessions, efforts can begin to fade the training and reinforcement procedures so the individual responds more independently, or to increase the skill level or complexity of the task (for example, by requiring the individual to complete more steps in a task analysis of a skill to gain a reinforcer). Continuing training beyond mastery in many situations has little benefit for the individual and may create a situation in which participating in training is punishing. In all of the skill acquisition programs reviewed at DSSLC, participation in a skill acquisition program was required for excessive durations beyond mastery before the program could be considered completed. • For Individual #054, a skill acquisition program written in April 2010 had continued unrevised for 17 months. A review of the data reflected mastery of the skill occurred several months prior to the site visit. There was no indication the program was being considered as having met completion. • For Individual #334, a program required that the individual demonstrate mastery for three consecutive months before the program would be considered to be completed. Since the previous site visit, DSSLC had initiated the use of the Murdoch library of training programs to enhance the quality of skill acquisition programs. This process was initiated on July 1, 2011. Based upon the documents reviewed, as well as reports from staff, only a limited number of skill acquisition plans using the Murdoch materials had been implemented since July. The Monitoring Team anticipates that a substantially greater number of programs will reflect the Murdoch materials by the time of the next site visit. Because of the limitations noted in the skill acquisitions programs, it was not evident that individuals living at the Facility could be expected to strengthen existing skills. Furthermore, based upon observations and record reviews, there were instances in which it could not be determined that individuals were protected from the loss of skills and abilities. • On 528B, an individual discarded a meal because of the lack of a preferred condiment for his meal. The individual was not provided with any prompting or instruction regarding how to obtain the desired condiment independently. It was also noted during the site visit that individuals experienced obstacles to movement to the community. In such circumstances, it is essential that individuals be provided training to minimize the potential obstacles and help the individual to transition to the community as easily as possible. Based upon observations and	

#	Provision	Assessment of Status	Compliance
		document reviews, it was not clear that the Facility offered adequate supports in relation to noted obstacles. • Individual #334: o One obstacle to movement to a more integrated setting was a history of unauthorized departure at the individual's previous community living environment. The team did extensively discuss in the PSP narrative a possibility for purchasing a bicycle for the individual to teach safety skills and staying within prescribed boundaries during his rides; however, no Action Plan was developed to address this obstacle. o There was one Action Plan developed to have Residential Services coordinate and schedule opportunities for the individual to participate in campus and community based activities and events, but there was no integration as to how to use the community-based events to address decreasing potential for unauthorized departures and/or increasing community safety skills. An additional limitation associated with inadequate supports and training is the potential for reliance upon unnecessary restraint or on the use of clothing or other items that might be unusual and stigmatizing. . • On 522D, Individual #153 was observed to be wearing kneepads. Upon inquiry, staff indicated the kneepads were protective devices because he would drop to the floor on his knees. Staff reported that the behavior had not occurred for a "long time", but that the kneepads were continued because "you never know." Staff went on, however, to indicate that the individual frequently removed the kneepads or wore the kneepads around his ankles. There were no skill acquisition programs or other habilitation supports intended to minimize the use of kneepads. It was encouraging that DSSLC had demonstrated progress in some areas related to skill acquisition programs. The noted progress, however, was not substantial and did not reflect systematic progress toward development of skill acquisition programming adequate to promote the growth, development, and independence of all individuals. Considerably greater focus upon formal teaching procedures will be needed before the facility can achieve substantial compliance with the SA.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to	During the baseline site visit in March of 2010, a review of the records for 10 individuals revealed that formal assessment of skills, needs, and abilities was lacking at DSSLC. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	community integration, in the areas of living, working, and engaging in leisure activities.	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 during that initial visit did not reveal formal and objective attempts to corroborate informal and subjective assessments. Only minimal changes had been noted in the course of site visits conducted since the baseline visit. As part of the current site visit, records were reviewed for 25 individuals living at DSSLC. The record reviews revealed that for 25 of 25 individuals (100%), documentation of annual assessments were available in the record. As reported in Section K, substantial limitations were found in the assessment reports and procedures. It was noted, however, that during the several weeks prior to the current site visit, DSSLC adopted the new Functional Skills Assessment (FSA) developed by DADS. The FSA reflected advancement from the previous PALS assessment. Rather than listing a variety of skills as either a strength or weakness, as was required by the PALS, the FSA was constructed more like a task analysis of a variety of skills. Each individual is rated by the level of prompting required for success on skill or task. This provided a more detailed representation of each individual's abilities. Despite the improvement represented by the FSA, it was not clear that the protocol was sufficient for skills assessment. One substantial limitation was the lack of granularity and individualization reflected in the FSA. For example, one item under "Household/General Safety" required the level of prompting necessary for the individual to cooperate with a fire drill. Cooperation during a fire drill is an important skill, but more information than just level of prompting is required to determine an individual's ability in this area. A second limitation was the apparent inability to assess those individuals with physical limitations upon the use of skills. For example, one item under "Meal Time Skills" was "Eats with a utensil". For some individuals, eating with a utensil would not be physically possible. For other individuals, extra time might be required to control fine motor coordination. These types of circumstances have no relation with the level of prompting required. The FSA included an area for comments on each item, but providing a comment about the inability of the FSA to measure the skills would not equate with assessing that skill. It would be unrealistic to expect that any instrument designed for the assessment of adaptive skills would possess the ability to capture all underlying circumstances for skill deficits. It is essential, however, that such an instrument include the means by which to measure the individual's abilities in the context of the individual's physical, developmental, cognitive, and environmental circumstances. Without the ability to capture the basic information about individual abilities within these contexts, any	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>assessment results would be of unclear benefit in understanding the individual's needed supports and services, or in the development of skill acquisition plans.

In many available instruments, this limitation is in part addressed by standardizing the instrument across variables such as physical ability, intellectual ability and living environment. The FSA reviewed at DSSLC was not a standardized instrument. Therefore, a greater burden is created to ensure that the findings of the FSA provide individualized and relevant insights into the needs of the person being assessed. Based upon the review at DSSLC, the FSA was unable to meet this burden.</td><td></td></tr>
<tr><td>S3</td><td>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:</td><td></td><td></td></tr>
<tr><td></td><td>(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</td><td>During all previous site visits, pervasive problems were noted regarding the implementation of skill acquisition programs. Only in very limited circumstances had staff been observed to implement formal training or offer prompts and reinforcement in the manner prescribed by the skill acquisition programs.

During the current site visit, observations were conducted in a variety of settings across the DSSLC campus in order to assess skill acquisition implementation. A sample of locations where individuals were expected to be involved in meaningful activities was selected for observational review of engagement and active treatment. The table below reflects the number and percentage of individuals who were engaged in any formal or informal activity that did not include stereotypic movement, self-stimulation, or other undesired behavior.

<table>
<tr><th></th><th>Staff present</th><th>Individuals present</th><th>Engaged</th><th>% Engaged</th><th>Ratio</th></tr>
<tr><td>9/21/2011</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>512A</td><td>2</td><td>6</td><td>2</td><td>33</td><td>1:3</td></tr>
<tr><td>512B</td><td>3</td><td>4</td><td>2</td><td>50</td><td>3:4</td></tr>
<tr><td>512C</td><td>2</td><td>7</td><td>0</td><td>0</td><td>2:7</td></tr>
<tr><td>512D</td><td>2</td><td>5</td><td>1</td><td>20</td><td>2:5</td></tr>
<tr><td>512 Lang. Enrich.</td><td>1</td><td>4</td><td>4</td><td>100</td><td>1:4</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

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		512 Rain Forest	1	3	3	100	1:3	
		PI1	2	7	7	100	2:7	
		PI2	2	5	3	60	2:5	
		PI3	1	3	3	100	1:3	
		ETC1	3	2	2	100	3:2	
		ETC3	4	5	5	100	4:5	
		ETC5	5	8	6	75	5:8	
		ICD120	5	3	2	67	5:3	
		ICD124	9	7	7	100	9:7	
		ICD128	5	24	9	38	5:24	
		522A	2	5	0	0	2:5	
		522B	1	5	0	0	1:5	
		522C	4	9	9	100	4:9	
		522D	3	7	3	43	3:7	
		9/22/2011						
		528A	2	1	0	0	2:1	
		528B	4	5	4	80	4:5	
		528C	2	3	3	100	2:3	
		528D	2	4	3	75	1:2	
		508A	6	11	10	91	6:11	
		508C	5	11	9	82	5:11	
			3.50	5.83	4.83	58%		

Although an engagement percentage of 58% initially appeared positive, many of the observations that reflected high percentages of engagement included small classroom or vocational settings in which high levels of engagement would be anticipated. When those environments were eliminated from the calculations, the level of engagement fell to approximately 31%.

Observations also reflected that the provision of active treatment in the individual apartments fell far below acceptability. In some circumstances, such as in the 512 residences, staff was frequently observed to fail to engage the individuals in the environment in meaningful activities.

- In 512C, staff appeared unfamiliar with the modes of communication used by the individuals living there. Despite the apparent confusion, staff made no attempt to use communication devices that were available.
- In 512D, although materials for activities were available on the tables, staff did not interact with the individuals or facilitate use of the materials. Only one individual was observed to make eye contact with a DCP. All DCPs in the

#	Provision	Assessment of Status	Compliance
		immediate area were engaged in paperwork. Four of 12 beds in 512D were occupied, with the individuals in bed lying in awkward positions. No interaction with these individuals was noted. Although unacceptable in terms of the provision of active treatment, none of the individuals in the 512 residences were at risk of personal injury. The same could not be said for the individuals living in the 522 apartments. During observations in 522 on 9/21/2011, in addition to a total lack of formal or informal teaching, multiple circumstances were noted that involved personnel who failed to recognize that individuals were at risk to individuals or failed to act to protect those individuals. A selection of the most egregious conditions is presented below. • On 522B, Individual #313 had a "ski chair with seatbelt" – a chair that allowed for mechanical restraint – for use during meals. Staff reported that, without the chair, the Individual would "get up and take off." There was no mention of or approval for the restraint in the records available on the home. • On 522B, Individual #664 was observed to repeatedly insert most of his hand into his mouth and throat causing him to gag and expectorate. Staff was not observed to interrupt the behavior or otherwise intervene. Upon inquiry, staff reported that the Individual did not engage in the behavior "too often", and indicated he engaged in the behavior because he was congested. • On 522C, Individual #731 was shaking his spoon so severely that food reached his mouth on only one of every 10 attempts. Staff did not investigate the shaking or act to provide assistance in eating. • On 522C, an individual sat with his head low and over his plate. He would fill his mouth with food and then inhale the food with a loud, gurgling sound. Staff did not respond to the individual's manner of eating, act to correct positioning, or ensure that aspiration was not occurring. • On 522D, Individual #432 was being fed. He sat in a chair with his legs drawn up in the chair before him, in a quasi-fetal position, and often would self-restrain by placing his arms inside his shirt. Upon inquiry regarding the positioning, DCPs indicated that he would "kick off the table and become aggressive" if not allowed to sit in this position. Staff was unaware of any efforts to replace this behavior with a more appropriate behavior. • On 522D, Individual #153 was observed to be wearing kneepads. Upon inquiry, staff indicated the kneepads were protective devices because he would drop to the floor on his knees. Staff reported that the behavior had not occurred for a "long time", but that the kneepads were continued because "you never know." Staff went on, however, to indicate that the individual frequently removed the kneepads or wore the kneepads around his ankles. This situation reflected a variety of potential problems. It was not clear that assessments regarding the	

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		use of kneepads were sufficient to determine the need for the devices. Reports by DCPs indicated that, regardless of identified need, staff did not consistently implement the protective devices that they had stated were required. In addition, staff comments reflected that they were unaware of any teaching needs associated with the use of protective devices. Following the observations on 522, the Monitoring Team informed the Facility of the conditions observed. The Monitoring Team was informed by staff that all personnel were then instructed to ensure that adequate active treatment was provided at all times and especially during meals. The Monitoring Team conducted observations during the evening meal to determine the level of response by staff. In the apartments in buildings 508 and 528, a substantially greater number of staff was observed. Despite the increased number of staff, several circumstances were observed that reflected a poor quality of active treatment, a lack of familiarity with the Individuals who lived in these homes, and a failure to act in the best interests of the Individuals. • On 528A, a man was engaged in an elaborate ritual of walking while going to receive medications. Staff did not respond to the individual or act to facilitate his receiving his medications. Twice, however, staff bumped into the individual and interrupted his ritual, which resulted in the Individual beginning the ritual again. • On 528A, DSPs were observed offering complex verbal instructions to individuals with hearing impairment or poor receptive verbal communication skills. • On 528B, an individual attempted to request mayonnaise for his sandwich. Although his verbalizations were difficult to understand, staff made no effort to use communication devices. After staff guessed correctly about the mayonnaise, the individual was informed that he would be brought what he requested. After 10 minutes, no mayonnaise was brought to the individual. He threw his sandwich in the trash, but was offered no alternative meal. Furthermore, there was no opportunity for the individual to get, or learn to get, mayonnaise independently—a skill that would not only make it more likely he could have his preferred condiment but also might be useful in moving to a more integrated setting. • On 528D, an individual was observed to gulp a glass of liquid. Staff offered a single prompt not to drink so fast. The individual continued to gulp liquids throughout the meal with no other further intervention. There was no evidence of a plan to either teach an alternative, safer way to drink or to modify the environment or way liquid was available so as to make drinking safer. • On all residences during the meal, staff did not implement dining programs as written. Although prompting was observed, the prompts consisted of specific commands rather than the prompts required for formal teaching.	

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		A review of the Facility's self-assessment materials indicated that DSPs and other active treatment staff had been provided additional training since July 2011. • 07/01/2011: Active Treatment Coordinators, Active Treatment Technicians and Building Coordinators attended class related to basic teaching methods. • 07/01/2011: Life Skills Department to begin using the Murdoch System for development of skill acquisition program objectives in PSP Meetings. • 07/01/2011: Expanded new employee orientation from 2 weeks to 4 weeks to include more competency based training, observations, and mentoring for new employees. • 07/01/2011: Competency Training and Development began collaborating with the University of North Texas and the Behavior Analysis Resource Center (BARC) in the development of competency based training for skill acquisition. • 07/01/2011: Life Skills and pilot group of QDDP's began using the Murdoch System for development of skill acquisition programs at PSP meetings. • 07/27/2011: "Tools for Effective Training" completed for ATC/ATT/Building Coordinators by Behavior Analysis Resource Center (BARC) of the University of North Texas to reinforce teaching methodologies for individuals. • 08/08/2011: QA Auditors began using revised engagement tool. • 08/30/2011 and 09/02/2011: QDDP's attended "Tools for Effective Training" by BARC It was encouraging that DSSLC had initiated enhanced training and mentoring of staff in relation to the development and implementation of skill acquisition training programs. Considering these efforts, however, the Monitoring Team was taken aback by the lack of formal or informal teaching being provided by the Facility, as well as the lack of knowledge of or concern for individual safety exhibited by those staff tasked with the provision of active treatment. Based upon the observations and document reviews completed as part of the current site visit, it was evident that DSSLC had not prepared staff to provide meaningful and functional supports. As a result, the individuals living at the Facility were less likely to acquire new skills, develop greater independence, or become better prepared to transition to the community. In addition, in some circumstances, adequate steps had not been taken to ensure that individuals were free from unnecessary risk of harm or unnecessary use of mechanical restraint. DSSLC must act aggressively and with all due diligence to ensure that the conditions observed during the current site visit are fully resolved very quickly.	
	(b) Include to the degree	At the time of the March 2011 site visit, DSSLC had generally increased the total number	Noncompliance

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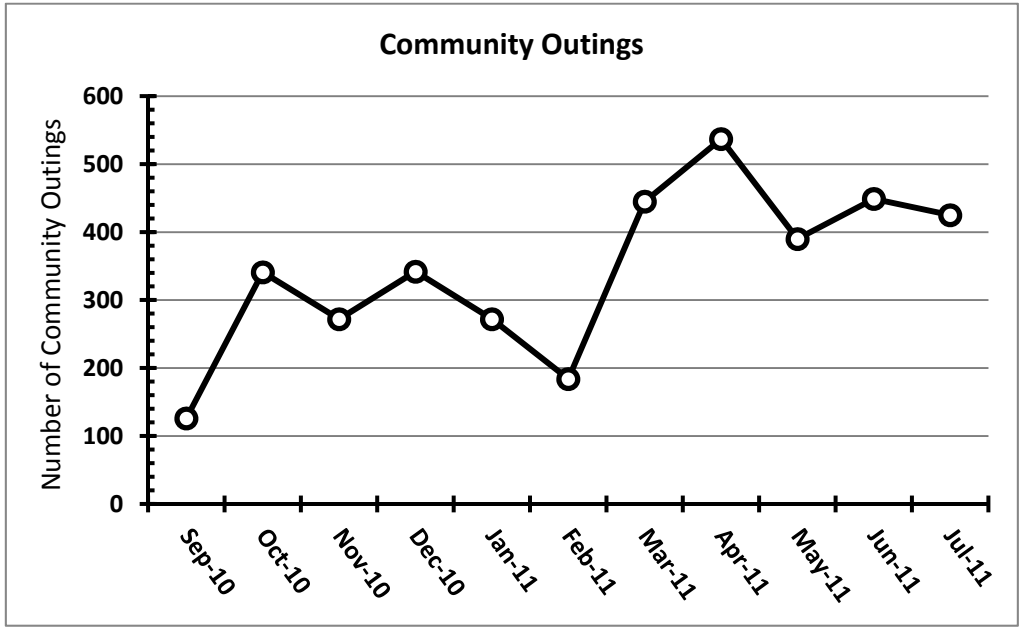
	practicable training opportunities in community settings.	of community activities compared with the same time frame from the previous year. A trend analysis, however, reflected a steady decline in the number of community activities in the First Quarter of 2011. This decline culminated in March where 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. During the current site visit, documentation reflected that DSSLC had reinvigorated the community outing process. A substantial increase in the number of community outings occurred in the second quarter of 2011. Although the number of outings reversed slightly with the onset of Summer, the number of monthly community outings remained substantially greater than earlier in the year. This reflected a very welcome achievement by DSSLC.  Some progress was also demonstrated in community employment for individuals living at DSSLC. During the previous site visit, six individuals were employed in the community. During the current site visit, it was noted that there were now 11 individuals with community jobs. This provision of the Settlement Agreement addresses not only the quantity of	

#	Provision	Assessment of Status	Compliance
		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 the same issues that limited effective skill acquisition programming at the Facility, as discussed in Provisions S1 and K, affected the quality of training in the community.	

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

1. The Facility must take steps to ensure that skill acquisition plans are developed according to the basic principles and practices of good skill acquisition training and reflect an evidence-based approach to the process of strengthen skills and abilities.
2. It is necessary that the Facility act to ensure that all assessments of skill, ability, and need provide a valid and individualized foundation for skill acquisition training. If standardized assessments of ability are not used, the Facility should take additional steps to document how the assessments accurately reflect the specific needs of each individual.
3. Effort must be made to ensure that all individuals living at DSSLC receive an adaptive assessment each year and have had an intellectual assessment within the past five years.
4. DSSLC must act aggressively and with all due diligence to ensure that all individuals living at the Facility are provided with formal and informal training.
5. It is necessary that the Facility expand efforts to ensure that skill acquisition training are fully implemented and documented in community settings.

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 09/07/2011 2. DSSLC's Report for Monitors, dated September 19, 2011 3. DSSLC Policy on Personal Support Planning Process, Policy Number CMGMT-12.01, dated 1/03/11 4. DSSLC Policy on Personal Support Planning Process Policy Number CMGMT-12.01, dated 8/05/11 5. Draft DADS Policy 018: Most Integrated Setting Practices, undated 6. Since on-site review a list of individuals who have been referred for community placement by his or her PST 7. Since last on-site review, a list of all individuals who have requested community placement, but have not been referred for placement 8. Since last on-site review, 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 last on-site review, a list of two individuals who have been discharged pursuant to an alternative discharge 10. Discharge Summaries and Discharge Packets for two individuals who have been discharged pursuant to an alternative discharge: Individuals #624 and #711 11. A current list of all alleged offenders committed to the Facility following court-ordered evaluations 12. A list of 517 individuals who have been assessed for placement for the period between 25-Aug-10 and 15-Aug-11, date of assessment, and resulting recommendation(s) 13. Community Placement Report, dated August 26, 2011 14. For the last twelve months, a list of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices 15. Since last on-site review, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed 16. Mental Retardation Authority (MRA) Community Living Options Information Process (CLOIP) Worksheets for 35 individuals; Individuals #19, #33, #61, #74, #79, 80, #92, #101, #102, #125, #164, #168, #171, #192, #209, #262, #290, #298, #371, #373, #438, #443, #485, #533, #549, #580, #595, #600, #626, #697, #715, #721, #749, #762, and #788 17. Personal Support Plans (PSPs) for Individuals #46, #269, #334, #546, #566, #627, and #739 18. Personal Focus Interviews (PFI) for Individuals #33, #61, #80, #102, #164, #373, #549 19. Completed CLDPs for four Individuals #120, #237,#384, and #618 20. Partial CLDPs for seven Individuals #217, #236, #354, #381, #432, #458, and #771 21. Pre-Move Site Review documents for four Individuals #120, #178, #237, and #618 22. MRA Continuity of Care Pre-Move Site Review Instruments for four Individuals #120, #178, #237, and #618 23. DSSLC report entitled *Obstacles to Community Transition*, undated

	24. DSSLC report entitled *Annual Report: Obstacles to Transition*, dated July 2011 25. Completed Post Move Monitoring (PMM) checklists for ten Individuals #77, #120, #178, #237, #406, #618, #634, #685, #792, and #795 **People Interviewed:** 1. Andy Maher, Director of Consumer and Family Relations (CFR) 2. Frank Padia, Director of Program Coordination 3. Lauri Cross, Post-Move Monitor 4. Jody Vicars-Nance, Admissions and Placement Coordinator (APC) 5. Berry Sudderth, QDDP (Qualified Developmental Disability Professional) Auditor/PFI Interviewer 6. QDDPs for Individuals #164, #269, #373, #384 **Meeting Attended/Observations:** 1. PSPs for two Individuals #61 and #80 2. Personal Focus Assessment (PFA) meeting for Individual #341 3. CLDP Meeting for Individual #384
	Facility Self-Assessment: The Monitoring Team reviewed the DSSLC POI. For the most part, the current POI simply reported on actions taken, rather than evaluating whether the actions taken are producing the desired outcomes, and why or why not. The POI did not provide details as to the Facility's self-assessment processes, but rather listed some actions the Facility had taken since the last visit and, in some cases, provided a list of Action Steps and completion status. The Facility should consider how it might use its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes. **For Provision T1**, the Facility indicated it was not in full compliance with many of the components for this provision. It did report it had achieved some level of compliance in several component areas, those being the review of the CLDP with the individual and LAR under Provision T1c3, the development of an annual report of obstacles to community transition under T1g and the issuance of a Community Placement Report under Provision T1h. The Monitoring Team concurred with the Facility's assessment in Provisions T1g and T1h, but did not find substantial compliance with Provision T1c3. For this latter provision, DADS and Facility policy required that the CLDP be reviewed with the individual and LAR at specified intervals throughout the CLDP process and documented as these occurred. The Facility was unable to provide evidence of these ongoing reviews as required. The Monitoring Team did find substantial compliance in Provision T1c2, which required that Facility staff be assigned responsibilities for actions related to the CLDP and that timeframes for completion be specified. 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 for this provision. These included ongoing training for QDDPs; identification and training of PSP facilitators; the design and implementation of a Personal Focus Interview Pilot program; requiring most integrated setting recommendations in all PSP assessments; and, the aforementioned development of an annual obstacles report. The Facility also reported a number of steps in process or recently completed related to developing and implementing a

	comprehensive community education plan. A more concentrated focus on measuring the outcomes of these activities would allow the Facility to assess whether the steps taken are effective. **For Provision T2**, DSSLC stated it was not in compliance with the PMM process, but the Monitoring Team found substantial compliance. In the POI, the Facility listed some of the actions the Facility had taken to take to address recommendations made at the time of the last monitoring visit for this provision, including developing a back-up plan to ensure completion of PMM visits even when the Post-Move Monitor is unexpectedly absent, ensuring all sites in which supports were provided were visited at each of the required timeframes, and holding weekly internal meetings to review and monitor ongoing transition activity. DSSLC also reported that deficiencies found in the provision of services were being reported to the sending PST. As a means of self-assessing ongoing progress, the Facility may want consider development of a database to track the outcomes of these reported deficiencies and/or to analyze trends in the types of deficiencies being found. Such data may allow the Facility and PSTs to continually improve their transition planning and processes. **For Provision T3**, no rating was required. **For Provision T4**, the Facility indicated it was in substantial compliance and the Monitoring Team concurred. The Facility policy was consistent with DADS policy as well as with CMS discharge requirements.
	Summary of Monitor's Assessment: DSSLC indicated that it was not in compliance with many of the provisions of this Section, but did report it had achieved some level of compliance in several component areas. The findings are as follows: **Provision T1:** This provision was determined to be not in compliance. In most instances the assessment of the Monitoring Team was consistent with the Facility's self-assessment in the component areas. The Facility reported it was in compliance with Provision T1g, the development of an annual report on obstacles to community transition, and with Provision T1h, the issuance of the Community Placement Report at required six month intervals. The Monitoring Team concurred with both of these assessments. The Monitoring Team did not concur with the assertion of substantial compliance in the review of the CLDP with the individual and LAR under Provision T1c3. DSSLC reported four placements in the past six months. 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. The Facility was not yet meeting the 180 day target for transition to occur, but there was some early evidence that the process was beginning to move at a quicker pace. There were fourteen pending referrals and the pace of PST referrals was also beginning to quicken. The Facility was to be commended for undertaking several initiatives to enhance the PSP process to better identify preferences for community living, to ensure that professional staff make recommendations regarding the most integrated setting and to provide effective facilitators in the development of the plans.

	Continuing training for QDDPs and other PST members was also underway and the results were evidenced in some meetings held during the site visit. At the same time, many of the planning processes continued to be hampered by a failure of the Facility to ensure the completion of adequate and timely assessments. The Monitoring Team strongly recommends the Facility take action, through policy directive, training and quality monitoring, to assure assessments are being completed in a thorough, accurate and detailed manner. **Provision T2:** This provision was found to be in substantial compliance. The Monitoring Team found that the PMM Checklists were being completed in a timely manner. The Post-Move Monitor did, at each visit, observe each site at which the individual lived, worked, or participated in day activity services. The Post-Move Monitor verified that each support was in place and being implemented. The Post-Move Monitor was to be commended for these continued improvements, especially in the enhanced thoroughness and documentation of follow-up to issues discovered in the PMM reviews. DSSLC also reported that deficiencies found in the provision of services were being reported to the sending PST. The Facility may want consider development of a database to track the outcomes of these reported deficiencies and/or to analyze trends in the types of deficiencies being found. Such data may allow the Facility and PSTs to continually improve their transition planning and processes **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 found to be in substantial compliance. The Facility policy was consistent with DADS policy as well as with CMS discharge requirements. Two alternate discharges to other SSLCs occurred during the last six months and appeared to have been completed within the requirements of the policy.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**	This Provision was found to be not in compliance.	
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	DSSLC continued to engage in many activities during the past six months to encourage and assist individuals to move to the most integrated setting. These activities were, as required, not opposed by the individual or the individual's LAR, and appeared to be made by taking into account the statutory authority of the state, and the needs of others with developmental disabilities. Funding did not appear to be an obstacle to any individual's transition. There were no confirmed instances of a placement being delayed or prevented due to lack of funding, although there was at least one instance during the site visit in which a PST member recommended that placement not be made due to the costs of needed dental care in the community; please refer to Provision F1e for more detail.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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 reported four placements in the past six months. 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. The Facility was not yet meeting the 180 day target for transition to occur, but there was some early evidence that the process was beginning to move at a quicker pace. There had been no returns of any individuals who had moved from the Facility. DSSLC had undertaken some actions to further assist PSTs to more effectively implement their responsibilities to encourage and assist individuals to move to the most integrated settings appropriate to their needs. Examples included: • All of the QDDPs at DSSLC had completed Q-Facilitation training and were receiving ongoing coaching and follow-up training from the DADS-certified trainers, as described in Provision F1a. This training included information on how to address the determination of appropriateness for movement to a more integrated setting. • Four staff certified in the Q-Facilitation had begun facilitating all PSP meetings, to both ensure the development of appropriate plans as well as to provide ongoing modeling of facilitation skills for the QDDPs. • DSSLC had also begun to receive external consultation centered on the PSP process, as reported in Provision F1a. This process was in the early stages of implementation. • DSSLC continued to provide opportunities for community education and awareness, including community tours, MRA annual inservice training and an annual Provider Fair, as described in Provision T1b2. • The presence of an effective transition monitoring process was in evidence and provided an essential component in assisting an individual to successfully move to community living. The effectiveness and thoroughness of this process should also serve to enhance the confidence of individuals, family members and LARs in the potential for that success. • An additional position had been added to the staffing within the Department of CFR to assist with the CLDP and transition processes in anticipation of a growing number of community referrals and placements. The Monitoring Team commends these activities and initiatives. As detailed in the rest of this Section T and in Section F above, however, outcomes in the areas of assessment and planning for protections, services and supports (see Provisions F1c, F1d, F1e, F2a1 F2ab, and T1b1); education for community awareness; (see Provision T1b2) and transition and discharge planning (see Provisions T1c1, T1d, and T1e) indicated the Facility could not be said to be effectively assisting and encouraging individuals to move to the most integrated setting yet.	

#	Provision	Assessment of Status	Compliance
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 provision was found to be not in compliance. The Facility reported there had been no changes in policy and procedure since the previous visit, but there had been some changes in policies and procedures related to encouraging people to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate. This included the development and implementation of DSSLC Policy CMGT-12.01, dated 8/05/2011 which outlined a pilot project to implement the PFA through a Personal Focus Interview process. The Facility also provided a copy of the DADS Most Integrated Setting Policy 018 in the T Presentation book. This version was still in draft and was undated, although the Facility reported in its POI it had received a revised Most Integrated Setting Policy Draft on 8/01/2011.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	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 was 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. This is described in more detail under Provision F1e above. The PSP process was predicated on beginning with a vision for the individual as the basis for identifying the supports and services that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. This vision was intended to be developed through the Personal Focus Assessment (PFA), completed by the individual, family and PST during the third quarter preceding the annual PSP. The Facility no longer held the PFA meeting as part of the third quarter Psychiatric Medication Review, as in the previous monitoring visit. Instead, a single staff person, a QDDP Auditor, had been designated to complete a Personal Focus Interview (PFI) in advance of the PSP meeting. Following the completion of the PFI, the interviewer typically produced a one-page listing of the identified preferences. The Monitoring Team attended a PFI meeting for Individual #341 and found it to be implemented effectively in many respects. The designated staff had familiarized herself with the needs and preferences of the individual prior to the meeting through talking with staff and record review. For the PFI, the interviewer gathered a small group of staff who knew the individual well, including direct support staff, day program staff and clinicians, along with the individual, to explore many of the questions included in the PFA. This process appeared to be much more intimate and comfortable for the individual than any others the Monitoring Team had attended in the past. The family did not participate, but the interviewer stated an intention to follow-up to discuss the PFI results	Noncompliance

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		with the family and obtain input. Overall, this appeared to be an improved process, but it still did not appear to address the needs of individuals to be active and ongoing participants in their own planning processes. 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. Additional details of this recommendation may be found in Provision F1b. The Monitoring Team attended three PSP annual planning meetings and reviewed seven PSPs completed using the new process and format for the purpose of evaluating this component. Consistent with the findings under Section 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. In the area of assessment of the most integrated setting appropriate to an individual's needs, the PSPs reviewed still did not consistently provide a professional assessment of the most integrated setting appropriate to an individual's needs. It was noted that team members had recently been provided clarification and training as to their individual responsibilities to make a recommendation about the most integrated setting. A review of the assessments for Individuals #46, #334, #546, and #566 for recently completed PSPs found that there were no (0%) professional recommendations regarding the most integrated setting. It was observed during at least one PSP meeting during the site visit that staff provided these assessments, so it is anticipated this will be more in evidence at the next site visit. In the area of the identification of needed supports and services in the most integrated setting, the PSTs continued to focus primarily on those supports being provided at the Facility. Assessments reviewed did not provide any specific recommendations regarding supports, protections and services that could be provided in a community setting. In the area of identification of obstacles and/or strategies to overcome those obstacles, the Monitoring Team found there were few Action Plans around specified obstacles. Examples included: • For Individual #334, the Optimistic Living Vision was to live in a small group home or a foster care home. The PST identified obstacles as 1) the individual's wish to remain at DSSLC and 2) that a prior community placement had been unsuccessful. The first obstacle was reported to have been identified by the individual looking away with no expression when asked about visiting	

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		community group homes. Based on this, the PST determined the individual was not interested in exploring community options at that time. The team also indicated education on community living was not needed since the individual had lived in a group home for seven years prior to admission to DSSLC in 2007. So, even though the team identified the Optimistic Living Vision to be community living, no Action Plan was developed to provide any education or awareness as to current options that might assist the team to better gauge the individual's interest. The second obstacle was based on a history of unauthorized departure at the individual's previous community living environment. The team did extensively discuss in the PSP narrative a possibility for purchasing a bicycle for the individual to teach safety skills and staying within prescribed boundaries during his rides; however, no Action Plan was developed to address this obstacle. There was one Action Plan developed to have Residential Services coordinate and schedule opportunities for the individual to participate in campus and community based activities and events, but there was no integration as to how to use the community-based events to gauge the individual's interest in community living or to address decreasing potential for unauthorized departures and/or increasing community safety skills. • For Individual #46, the individual's parents indicated some openness to community living at the PSP, but stated the MRA had informed them there was nothing available for the individual in the community. This was then reported as an obstacle. The PST discussed the possibility of the parents attending an upcoming Provider Fair as a means for learning about potential community living options, but no Action Plan for this, nor any other education or awareness activity, was developed. It was noted that the parents did attend the Provider Fair held in September 2011, but there was no formal Action Plan for any follow-up to this activity. Since the Provider Fair had just occurred, it was too early to assess whether the Facility might make follow-up contact with the family or take any additional actions. However, as documented in Provision F2d, the Facility did not consistently implement strategies for which formal Action Plans existed, nor was there any evidence that such planning had been started for this individual since the Provider Fair. • For Individual #627, the PST identified the major obstacle to community living would be the reluctance of his family. The PST appropriately offered to assist and accompany the family on tours of some community programs, and the family agreed to consider that. The PSP indicated a referral or community tours would be made; however, no Action Plan was developed.	

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	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	This component was found to be not in compliance. DSSLC reported in the POI it had developed a comprehensive plan for education and awareness, including a variety of activities. The Facility did not provide as evidence a formal, written document with goals, timelines and/or assigned responsibilities. There was however, some data available to support an increase in educational activities over the past six months, at least in the area of offering individuals opportunities to tour community homes and programs. 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 community tours from April through August 2011. For April and May, there were only four tours indicated to have been made, but the list did not include the names of individuals who participated. From June through August, the Facility reported 26 tours had taken place, involving more than 60 individuals (with a few individuals making more than one tour.) This was a much improved pace of tours over the previous months. The Facility also reported it was planning to engage QDDPs for individuals with open referrals for community living to encourage more tours. The annual MRA CLOIP process continued to comprise a significant portion of the Facility's overall plan for education and awareness for individuals, but 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 of 35 CLOIP Worksheets, including 28 completed for PSPs held in the month of August 2011 and seven for PSPs being held during the week of the site visit. For 13 of the 35 (37%), the LAR did not allow the MRA Service Coordinator to provide the individual with information about living options. For 19 of the 35 (54%), 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 process, materials and/or information should be modified to better meet the needs of the individuals. Overall, DSSLC still failed to adequately assess, plan for, and implement a plan for each person's needs for education and awareness, as described in Provisions T1, F1 and F2. 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. These plans could include, and integrate, purposeful community integration activities; community tours; self-advocacy; community work, job exploration, and volunteer activities; developing and/or maintaining relationships with people living and working in the community, and other approaches the Facility might explore and create. All of these provide opportunities for increasing awareness of community living and should be considered in developing an integrated and individualized strategy for	Noncompliance

#	Provision	Assessment of Status	Compliance
		each individual. DSSLC had taken other actions to increase education and awareness about community living options over the past six months for staff and families. Examples included: • Preparing Facility staff to engage individuals, families and LARs in discussions about community living is another essential ingredient in the provision of adequate education 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.. • DSSLC held its annual Provider Fair on September 9, 2011. Attendance signature sheets documented participation by approximately 40 provider representatives, 70 individuals, 69 staff and four family members. The Director of CFR reported that an individual who had moved from the Facility was invited back to participate and turned out to be the "star of the show," with many individuals still residing at the Facility remembering her. This was the sort of opportunity that assists individuals to have a meaningful understanding of what community living might be like. • The MRA annual inservice was held on 9/2/2011 and was attended by approximately 60 staff per the provided attendance signature sheets. The inservice was entitled "Developing Community Services for Everyone" and was reported to have focused on the kinds of services and supports available in the community and how they could be individualized to meet specific needs and concerns.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such	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 Draft Policy 018: Most Integrated Setting Practices, undated. The Facility provided a list of 517 individuals who had been assessed for placement between 25-Aug-10 and 15-Aug-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, T1a, and T1b above, this did not yet appear to be the case. The ability of the PSTs to engage in critical thinking, interdisciplinary assessment and actual person-centered planning was still developing and continued to require considerable investment in staff training and mentoring.	Noncompliance

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	policies, procedures, and practices.	There had been improvements in this area. DADS had provided clarification for PST members as to their individual responsibility to assess each individual for the most integrated setting appropriate to his/her needs, staff training had been provided, and there was some evidence that the most recent assessments included recommendations from professionals as to the needs for supports and services in the most integrated setting. At least one PSP observed, for Individual #80,included formal input as to the most integrated setting from each of the PST members during the Living Options discussion.	
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 Draft Policy: Most Integrated Setting Practices 018.1, undated. The Monitoring Team reviewed the Community Placement Report, dated August 26, 2011. Of the five community placements that had occurred since April 2011, zero (0%) were completed within the 180 day timeframe. According to Community Placement Report three of the ten current active referrals (30%) had already exceeded the 180 days, as well. These data may not have been completely reliable, however, and may have resulted in under-reporting the number of individuals who did not complete transition within 180 days. For example, at least one individual on the list of current referrals (Individual #381) was known to the Monitoring Team to have been referred at least a year earlier. When this was posed to the Director of CFR, he indicated that a new date may have been assigned in the Avatar database but was not sure why this may have occurred. DADS should examine if this was an isolated incident, or whether there is a potential flaw in the procedure or database maintenance that results in inaccurate reporting. The Facility should also ensure that timeliness of actions related to referrals and community placements are included in its development of the quality assurance procedures required under Provision T1f. The Monitoring Team recognized that exploration and development of individualized community living options can be a time-consuming process and that there are situations in which the 180 day timeframe will appropriately be exceeded. DADS policy also acknowledges this and provides an avenue to apply for and receive a waiver when needed. It is recommended the quality assurance approach focus on whether an adequate and reasonably intensive exploration and development process is taking place. For example, the Facility could collect data regarding the number and types of community exploration activities undertaken for each individual on the list of current referrals.	Noncompliance

#	Provision	Assessment of Status	Compliance
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The 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 the PSTs did not demonstrate proficiency in overall needs assessment, the interdisciplinary process necessary to integrate the assessment findings into a comprehensive support plan, or the identification during the PSP planning meeting of the supports and services needed and desired in a community setting, as described in Provision 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 #384. The Monitoring Team identified health concerns and other needs the team concurred with, but had failed to assess prior to the CLDP meeting. Examples included: • The individual had a significant weight loss over the past year, combined with a history and/or active diagnoses for a number of gastrointestinal issues. No clinical evaluation had been undertaken by the Facility to determine the cause of the weight loss, and this was not identified to the community provider as a matter of concern. • The individual had a diagnosis of PKU, but was not receiving a PKU diet. The individual had not been seen for an evaluation of his status in this regard in at least three years. Potential concerns related to this had not been shared with the Provider for follow-up in the community. • The individual had tested positive for Hepatitis B in the past, but the provider had not received any information about any need for infection control. • A record review by the Monitoring Team revealed there had been recent occasions in which the individual had slipped down in his chair and under a seatbelt, a situation with the potential for extreme harm. No member of the PST was aware of this and was therefore unable to communicate this potential for harm to the community provider. • A Speech-Language Pathologist had recently been evaluating the individual for use of an augmentative communication device and demonstrated it at the CLDP meeting. Neither the Speech-Language Pathologist nor any other member of the PST was aware the individual had a PSP Action Plan to receive training on using certain hand signals to indicate yes or no. The QDDP was not aware this was	Noncompliance

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		included in the current plan and it was not being implemented. As the Monitoring Team raised these discrepancies and potential problems, it became necessary for the PST to postpone the CLDP until information could be gathered to ensure adequate supports and services could be identified. The Monitoring Team reviewed the final CDLP after the conclusion of the site visit and found that the issues appeared to have been addressed. It will be critical to the CLDP process in the future that adequate assessment processes, including attention to detail by individual clinicians, be in place at the Facility.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	This provision was found to be in substantial compliance. Three of three (100%) CLDPs completed since the last site visit specified the Facility staff who were to be responsible for ensuring the necessary actions had been taken and the timeframes in which such actions were to be taken. For the one CLDP observed during the site visit, the PST was not able to complete the listing of essential and non-essential supports. The final CLDP for this individual was received and reviewed following the site visit and was in compliance with this requirement.	Substantial Compliance
	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.	This component was found to be not in compliance. 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. CLDPs did not always contain evidence that they were reviewed with the individual and, as appropriate, LAR. For zero of seven CLDPs in process (0%) was there ongoing documentation being kept of the review with the individual and LAR in the CLDP document. On the other hand, for three of three (100%) completed CLDPs for individuals who had already moved there was documentation of the review and deliberation in the final document. It would appear that the revised CLDP is not being used as envisioned to document the process on an ongoing basis, but that this information is being added prior to the document being finalized. The Monitoring Team recommends the Facility implement and document in the CLDP on an ongoing basis as required. The Director of CFR reported that the Facility would be implementing this process as required by policy in the near future.	Noncompliance
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. Obtaining updated assessments from various professionals and ensuring they are current, accurate and available at the CLDP and for the use of the selected provider is an important step. The Facility must ensure the assessments are completed and/or updated within 45 days prior to the individual's move to the community in order to be considered current. It was not clear that the Facility had a quality assurance process in place to ensure that updates were available as needed. For Individual #120, the CLDP documented that the PST met	Noncompliance

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		to review current assessments on 3/15/2011. At that time, the PST identified the need for updates in nursing, habilitation therapies, medical, behavioral and nutritional areas to be completed as soon as possible, but no later than 4/4/2011, as a CLDP was to be scheduled for 4/11/2011. The CLDP later documented receiving all but the medical assessment on dates ranging from 3/16/2011 through 4/27/2011. After the CLDP meeting was held on 4/11/11, it became necessary to postpone the move date until 5/17/2011, which was appropriately documented in the CLDP. However, there was no indication that any of the assessments that might have been completed more than 45 days prior to 5/17/2011 had been updated. At a minimum, the Nursing and hab therapies assessments were completed outside of the required 45-day timeframe. In addition to these issues of timeliness, assessments were not being consistently well integrated into a comprehensive assessment in a manner that allowed for the CLDP to adequately 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. As described in Provision T1c1, the Monitoring Team identified significant health concerns and other needs for Individual #384 the PST had failed to assess prior to the CLDP meeting. The Monitoring Team did not review closed records for other individuals who had moved to the community to ascertain whether assessments completed prior to their moves accurately reflected their needs for supports and services, but the findings for Individual #384 called into question the assessment processes and findings that must form the basis for this required comprehensive 45-day assessment. The Monitoring Team interprets this requirement of comprehensiveness to include that the assessment must accurately reflect needs for supports and services, not simply that assessment documents be produced within 45 days of departure. The Monitoring Team strongly recommends the Facility take action, through policy directive, training and quality monitoring, to assure assessments are being completed in a thorough, accurate and detailed manner.	
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	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 four individuals who had transitioned to the community since 4/1/11. Four of four (100%) 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 attached for three of four	Noncompliance

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	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.	(75%) of the instruments made available to the Monitoring Team for review. DSSLC should ensure that complete documentation is kept as required at all times. The revised CLDP process also required the Facility to also complete its own pre-move site visit prior to the individual's transition date. The Monitoring Team reviewed the Pre-Move Site Reviews for the same four individuals noted in the previous paragraph. These also appeared to be thorough and completed in a timely manner. The Monitoring Team noted one item of concern that surfaced during the MRA Continuity of Care Pre-Move Site Review for Individual #120 that called into question whether the process was effectively implemented. The MRA noted that the provider was not in possession of the individual's CLDP at the time of the site review, but that the provider did know the supports needed. Since no other circumstances or follow-up were noted, it was unclear why the provider did not have the CLDP, nor how the MRA Continuity of Care Pre-Move Site Review should have served to correct this deficiency in ensuring the requisite continuity of the CLDP process. This may have been indicative of a communications breakdown between DSSLC and the provider at a critical juncture in the transition process, which the MRA Continuity of Care Pre-Move Site Review should not only identify, but also serve to help remediate.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	This component was found to be not in compliance. The Director of CFR had begun to meet on a weekly basis with staff to monitor status of transition activities, and 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. There was an assessment tracking form for the CLDPs the Facility had begun to use, but it was not clear this had yet had any impact on the timeliness of receipt of assessments. These initiatives were to be commended, but the reviews of the CLDPs from this site visit, as described in Provisions T1d and T1e above, and of the progress of referrals, as described in Provision T1c, would suggest the Facility needed to develop or otherwise promulgate written quality assurance procedures that would ensure CLDPs are developed based on an accurate and comprehensive assessment procedure, and that CLDPs adhere to the requirement of policy and procedure. 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; • CLDP 45 day assessments are completed within this timeframe prior to departure.	Noncompliance
T1g	Each Facility shall gather and	This component was found to be in substantial compliance. The Facility had begun to	Substantial

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.</td><td>collect data related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. In response to a request for a printout of the database/report summarizing the obstacles identified for individuals' movement to the most integrated setting appropriate, the Facility provided an undated document entitled Obstacles to Community Transition. This document indicated the Facility began to collect obstacles data on April 18, 2011. This information was reportedly obtained through discussion during annual Personal Support Plan meetings and submission of a completed report for each individual to the Quality Assurance Department, which reviews on a quarterly basis. Obstacles to transition identified from DSSLC, 2011 FYTD, were reported as follows:

<table>
<tr><td>Lack of supports for people with significant challenging behaviors</td><td>0</td></tr>
<tr><td>Lack of specialized mental health supports</td><td>0</td></tr>
<tr><td>Need for services and supports for persons with forensic needs/backgrounds</td><td>0</td></tr>
<tr><td>Need for environmental modifications to support the individual</td><td>2</td></tr>
<tr><td>Need for transportation modifications to support the individual</td><td>0</td></tr>
<tr><td>Lack of availability of specialized medical supports</td><td>10</td></tr>
<tr><td>Lack of availability of specialized therapy supports</td><td>0</td></tr>
<tr><td>Lack of specialized educational supports</td><td>0</td></tr>
<tr><td>Need for meaningful employment and supported employment</td><td>0</td></tr>
<tr><td>Lack of funding due to an individual's legal and citizenship status</td><td>0</td></tr>
<tr><td>Individual's reluctance for alternate placement</td><td>29</td></tr>
<tr><td>LAR's reluctance for alternate placement</td><td>103</td></tr>
<tr><td>Other</td><td>1</td></tr>
</table>

This report further indicated that DSSLC had completed a small survey with large providers in Dallas, Denton, Tarrant, and Grayson counties to gather more information on what supports are most difficult to obtain for people receiving HCS services. The document did not elucidate the findings of the survey, information which would be helpful in completing an actual analysis of the obstacles.

In response to a request for the most recent report of the Facility's analysis of major obstacles to individuals' movement to community living identified by the SSLC, the Facility also provided an Annual Report: Obstacles to Transition, dated July 2011. This contained essentially the same information related to obstacles as the previously cited report. Both documents indicated the Facility intended to continue to identify and collect obstacles to most integrated setting through the PSP process, to provide training to PST's on how to identify obstacles through the Consumer and Family Relations Department and state office resources, and to work jointly with PST's to develop action plans for</td><td>Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		obstacles, particularly for individuals who need to better understand community living options. These initiatives were an excellent beginning towards an effective capacity to identify and address obstacles to community living. The Monitoring Team encourages the Facility to continue to work toward a robust capacity in this regard.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	The Facility issued a Community Placement Report on August 26, 2011, covering the period of 9/1/2010 – 8/26/2011. The report was in the standardized format as prescribed by DADS State Office. It listed: • Eight community placements • Fourteen current referrals • One rescinded referral • Five individuals who preferred community, not referred-LAR choice • Eight individuals who preferred community, not referred-other reason • None for LAR prefers community – not referred It was not clear how the data reported in the Facility's *Obstacles to Community Transition* under Provision T1g correlated with data reported in the Community Placement Report as to those who were not referred due solely to LAR Choice. The Community Placement Report listed only five individuals who were not referred due to LAR Choice, but the former report listed 103 individuals for whom LAR reluctance was an obstacle as reported by the PSTs. At the same time, only 29 individuals were reported to have expressed reluctance as a barrier. The Facility should complete an analysis to determine whether these data are being consistently and/or accurately categorized and reported.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	This provision was found to be in substantial 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 ten individuals, all of whom received monitoring by the DSSLC Post-Move Monitor. Three of these individuals moved from facilities other than DSSLC. The Monitoring Team found that the PMM Checklists for ten of ten individuals (100%) were being completed in a timely manner. The Post-Move Monitor did, at each visit, observe each site at which the individual lived, worked, or participated in day activity services. There was also considerable progress noted in the process used to complete the PMM Checklists. The PMM Checklists reviewed during this compliance visit provided in-depth information that painted a picture of the individual's adjustment. The Post-Move Monitor verified that each support was in place and being implemented. If there were supports that were not in place as required, the Post-Move Monitor had taken actions and maintained a comprehensive record of emails and phone logs that documented careful follow-up and loop closure. No deficiencies in the process were found. As described in Provisions F 1c, F1d, F2, and T1c1, there continued to be some barriers to thorough PMM review as a consequence of the failure of the PSTs to adequately assess the needed supports of individuals either at the Facility or in the community. The PSTs also did not yet provide adequate direction to the Post-Move Monitor as to the evidence required to accurately ensure the presence of essential and non-essential supports. For example, in many instances the PSTs continued to indicate the evidence required to verify essential supports related to training were to be only a training roster. The PST should clearly state the necessity to interview and observe for staff compliance and knowledge in addition to the paper review of a training roster. The Monitoring Team found that the Post-Move Monitor consistently observed, interviewed and otherwise substantiated the presence of supports regardless, which was to be commended, resulting in a thorough review, but PSTs must also provide specific instruction in the CLDP.	Substantial Compliance
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move	This provision was found to be in substantial compliance. The Monitoring Team accompanied the Post-Move Monitor on a PMM visit for an individual (#792) who had transitioned from another SSLC. The monitoring process was observed and was found to be thorough. Supports were observed and/or documentation reviewed to confirm the presence of all essential supports. This process was also followed for non-essential	Substantial Compliance

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	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.	supports; when these supports had not yet been implemented, the Post-Move Monitor questioned the provider's plan for ensuring the supports would be obtained as required. The Post-Move Monitor was clearly familiar with the individual and the supports required, even beyond those specified in the PMM Checklist. It was evident that the Post-Move Monitor was well-known to the individual and there was a good, respectful rapport between the Post-Move Monitor and the individual, as well as with the provider staff.	
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.	
T4	**Alternate Discharges -**	This Provision was found to be in substantial compliance	Substantial 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;	This provision was found to be in substantial compliance. The Facility reported two individuals had been discharged pursuant to an alternative discharge as defined in the Settlement Agreement. These appeared to have been completed in a manner that would be consistent with CMS-required discharge planning procedures as well as with protocols established in DADS SSLC Draft Policy 018: Most Integrated Setting Practices, undated. The latter policy described a procedure and provided a format for a Discharge Reassignment Summary. DSSLC adhered to these requirements in these two discharges, both of which were transfers to another SSLC.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(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.		

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

1. The State and Facility should consider how it might expand its supports for 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. (Provision T1b1)
2. 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. (Provision T1b2)
3. The Facility should further develop its comprehensive strategic plan for education on community living options with assigned responsibilities, timelines and outcome measures. (Provision T1b2)
4. 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. (Provision T1b2)
5. DADS should examine if there is a potential flaw in the procedure or database maintenance for community referrals that results in inaccurate reporting. (Provision T1c)
6. It is recommended the quality assurance approach for ensuring timeliness in the CLDP focus on whether an adequate and reasonably intensive exploration and development process is taking place. (T1c)
7. The Facility should implement and document in the CLDP on an ongoing basis as required by policy. (Provision T1c3)
8. The Monitoring Team strongly recommends the Facility take action, through policy directive, training and quality monitoring, to assure assessments are being completed in a thorough, accurate and detailed manner. (Provision T1d)
9. 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. (Provision T1f)

10. The Facility should complete an analysis of data collection regarding referrals not made due to LAR Choice to determine whether these data are being consistently and/or accurately categorized and reported. (Provision T1h)
11. The PST should clearly state the necessity to interview and observe for provider staff compliance and knowledge in addition to the paper review of a training roster. (Provision T2a)

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Denton State Supported Living Center (DSSLC) Plan of Improvement (POI), updated 09/07/2011 2. DSSLC's Report for Monitors, dated September 19, 2011 3. List of Legal Guardians Assigned for 362 individuals, dated Tuesday, September 13, 2011 4. Prioritized list of 173 individuals who are in need of an LAR 5. List of New or Successor Guardians, for 12 individuals, undated 6. Agendas and/or Minutes for meetings of the Family Association of Denton State Supported Living Center for February 27, 2011, June 26, 2011 and August 28, 2011 7. Personal Support Plans and Rights Assessments for Individuals #46, #269, #334, #546, #566, #627, and #739 8. DSSLC Policy and Procedure Client Management-04 Legal Consent, dated May 11, 2006 9. DSSLC Policy and Procedure Client Management – 27 Affirming and Protecting Rights 10. DSSLC Policy and Procedure Client Management-30 Guardianship/Advocate, dated September 16, 2011 11. Draft DADS Policy on Guardianship/Advocate, dated 09/09/2011 12. Guardianship Committee meeting minutes, dated 9/12/11 13. Guardianship Committee training packet 14. Document entitled Guardianship and Conservatorship in Iowa: Issues in Substitute Decision Making **People Interviewed:** 1. Andy Maher, Director of Consumer and Family Relations (CFR) 2. Sezer Ruzek, Human Rights Officer (HRO) **3.** Pam Garrett, HRO **Meetings Attended/Observations:** 1. PSPs for Individuals #61 and #80 2. Personal Focus Interview (PFI) for Individual #341 3. Human Rights Committee meeting
	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. For the most part, the current POI simply reported on actions taken, rather than evaluating whether the actions taken are producing the desired outcomes, and why or why not. The POI did not provide details as to the Facility's self-assessment processes, but rather listed some actions the Facility had taken since the last visit and, in some cases, provided a list of Action Steps and completion status. The Facility should consider how it may use its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes. 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. These included ensuring its priority list was up-to-date and consistent with the information in other databases, localizing the new statewide policy

	on Guardianship/Advocate, developing a comprehensive rights education plan and attending PSP meeting at the Facility on a regular basis. This latter activity was used to provide training to the PSTs on the new policy requirements.
	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. A summary of the findings follows: **Provision U1:** This provision was determined to be not in compliance. A statewide draft policy on Guardianship had been recently promulgated, as well as a local Facility version based largely on the statewide document. The statewide policy did not contain any substantial guidance for the Personal Support Teams (PSTs) in terms of a standardized tool and/or process for assessment of decisional capacity, a much needed resource in the opinion of the Monitoring Team. There was still no standardized approach in use to assessing and determining the actual need for an LAR on an individualized basis that was consistent with currently accepted professional standards of practice, but the Facility had received permission from DADS to pilot the use of a tool found from another state. The Monitoring Team commends the initiative of the Facility in this regard, but urges staff to continue to research decisional capacity materials to augment the tool in question. The proposed instrument provides a number of important questions to ask regarding decisional capacity, but no real guidance as to how the answers to the questions might allow the examiner to form a differential judgment and/or develop strategies to enhance an individual's capacities in this area. The Facility did continue to maintain a prioritized list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision, but its prioritization process was not consistent with either the statewide policy or DSSLC's own localized version. **Provision U2:** This provision was determined to be not yet in compliance. DSSLC reported a number of activities in the area of guardianship education during the past six months. The HROs continued to attend and make presentations at the Family Association meetings. In addition, they had developed and begun to implement an Education Action Plan that included enhancing the support for Self-Advocacy, education and training around the new guardianship policy and attendance at PSP meetings. One of the most significant undertakings in this area had been the recent development and orientation of the Guardianship Committee. The Monitoring Team commends these educational activities on the part of the Facility and the HROs, but would also like to reiterate the following: As part of the Facility undertaking an effective and appropriate large-scale effort to solicit guardians, the Facility should ensure it has an appropriate methodology in place to determine the actual need for guardianship. DADS should provide guidance on such a methodology as soon as possible since appropriately determining who needs a guardian, and for what areas of decision-making, must be a prerequisite to recruiting and obtaining guardians for those individuals.

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U1	Commencing within six months of	DSSLC had recently received a draft statewide DADS Policy: Guardianship/Advocate,	Noncompliance

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	the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	dated 09/09/2011. The HROs had localized this policy draft into DSSLC Policy and Procedure Client Management-30 Guardianship/Advocate, dated September 16, 2011. There were no significant differences from the draft statewide policy presented. The Monitoring Team reviewed the policies. The stated purpose 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 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 stated "…the personal support team (PST) will discuss individual decision-making abilities and guardianship needs at the person-directed planning meeting for each individual residing in the center." While the policy provided a set of criteria for prioritizing once need for guardianship was established, it did not provide any guidance as to the considerations or deliberations required to make the initial decision that guardianship was needed. For individuals who do not currently have an LAR, are unable to give legally adequate consent, and are unable to express their wishes, the PST is further instructed in Attachment A, Guardianship Procedures,: to either 1) decide whether to pursue an LAR if there is an actively involved person in the individual's life, or, 2) if there is not an actively involved person, contact the Guardianship Coordinator to solicit the assistance of the Guardianship Committee in obtaining an LAR. This process required the PST to both assess the ability to give legally adequate consent as well as to decide if this may merit obtaining an LAR It was not reasonable to vest the PST with responsibilities of such import without providing them with some measure of guidance and/or training in how to undertake them. 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 guardianship was required. The HROs reported that DADS was continuing to examine how to best approach assessment of decisional capacity. In the interim, DSSLC staff had taken some steps internally to develop a strategy for such guidance for the PSTs. The Director of CFR and the HROs had identified an assessment process from Iowa, found in a document entitled *Guardianship and Conservatorship in Iowa: Issues in Substitute Decision Making*. The Facility reported it had sought and received permission from DADS to implement a pilot	

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		to test the efficacy of using this assessment tool, although there was no formal research design at this time. The Facility is to be commended for taking this initiative to assist the PSTs in carrying out their responsibilities under the new policy in the absence of any further current guidance from the state level. The Monitoring Team reviewed a copy of the document. The assessment tool portion of the document would lead the team to ask a number of important questions regarding an individual's functional capacities in many areas of life, but it did not provide any methodology for translating the answers to these questions into a framework for assessing decisional capacity, either as a whole or in discrete areas. The Facility should consider additional resources regarding decisional capacity, which exist nationally, that may further inform and amplify the development of this strategy. A sampling of such resources include:: • *Decisions By and For People with Mental Retardation: Balancing considerations of Autonomy and Protection*, James W Ellis; • *Decision-Making Capacity in Adults: Its Assessment in Clinical Practice, Bellhouse,* et al; • *Alternatives to Guardianship* on-line training found at maine.gov/guardianship, which provides additional assessment documents; and, • A variety of resources found at guardianship.org At the time of this site visit, however, the PSTs continued to address the ability of an individual to provide informed consent in the annual Rights Assessment, but this process was still not predicated on any objective criteria. The PSTs were not using an individualized assessment process to determine that an individual was or was not capable of giving informed consent, or to what extent or for what discrete purposes guardianship or other decision-making assistance was required. The Monitoring Team reviewed seven Rights Assessments and the respective PSPs, completed since the last site visit and provided as part of the document request in response to request V.3. The findings were as follows:: • For zero of seven Rights Assessments (0%), did the PST check off that the person was able to give informed consent in any one or more of the categories included in that section. • For zero of seven Rights Assessments (0%), was there documentation to be found in the Rights Assessment of any appropriate standardized tool or process used to justify the PSTs assessment of the individual's capabilities to make decisions or to participate in decision-making. • For zero of the seven PSPs (0%), did the PSTs develop action plans to assist individuals to maintain or improve decision-making capacity related to any of the categories included in the Informed Consent section, other than a money management program tied to another specific rights restriction in that area.	

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		The Monitoring Team also attended a portion of a Human Rights Committee meeting. For zero of two Rights Assessments reviews observed (0%), was there any discussion of the individual's capacity to give informed consent, or of any strategies to enhance the individual's decision-making capacities. The Human Right Committee should receive some guidance as to the need to consider the informed consent restrictions with the same gravity afforded the other restrictions noted in the Rights Assessment. This recommendation was shared with the HRO who acted as Chairperson of the Human Rights Committee. The Monitoring Team also attended two PSPs and one PFI in order to evaluate how the PSPs were addressing decisional capacity and the development of any strategies to enhance the individual's decision-making capacities. While there were improvements noted in the processes for the PSP and PFI overall as described further in other sections of this report, including Sections F and T, the PSTs did not address these capacities in any significant way, nor did they develop any strategies to further enhance or support them. Despite these deficiencies in the processes for determining decisional capacity, DSSLC was maintaining a prioritized list of individuals purported to be lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision. The list was undated and included the names of 173 individuals. According to the HROs, they had begun to use the findings of the Integrated Risk Rating assessment to assign a priority rating from 0-11. This process was not consistent with the prioritization criteria described in either the statewide policy or the DSSLC version. It is recommended the Facility either adhere to the prioritization process in the policy as written, or apply to DADS for a variance from the statewide policy and incorporate their actual process into the DSSLC version.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for	Since 1/31/11, the Facility reported twelve guardians had been obtained. Six of these were reported to be successor guardians for individuals who had previously been adjudicated as in need of an LAR, but whose guardianship had lapsed for one reason or another. The remaining six were new guardianships. The DADS draft policy on Guardianship and DSSLC Policy 30 specified that, as the Guardianship Coordinators, the HROs would play an important 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. DSSLC reported a number of activities in the area of guardianship education during the past six months. They continued to attend and make presentations at the Family Association meetings. In addition, the HROs had developed and begun to implement an Education Action Plan that included enhancing the support for Self-Advocacy, education and training around the new guardianship policy, and attendance at PSP meetings. The Monitoring Team particularly commends the HRO	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	participation in the PSP process as a means of educating the PSTs. One of the most significant undertakings in this area had been the development of the Guardianship Committee. The HROs implemented a campaign to recruit membership for this committee. It was reported that the membership currently included three individuals, six guardians and five DSSLC staff. The Facility may want to consider whether this composition adequately meets the intent of the statewide policy, which specifies that members of the Committee "should include existing LARs, interested family members, individuals, staff and impartial members of the community as appropriate." The current membership does not appear to be inclusive of, for example, family members who have chosen another path besides guardianship toward supporting decision-making for a loved one. Having a variety of perspectives in this area would appear to be a vital requirement. The organizational meeting for the current membership of the Guardianship Committee was held on 9/12/11. The training packet provided for review included most of the required components per the policy, including training on individual rights, aspects of informed consent, confidentiality, and the guardianship process; however, it was missing any actual description of the responsibilities of the Committee. There was a page entitled Guardianship Committee Responsibilities, but this document simply listed membership criteria rather than responsibilities. According to the policy, the "Guardianship Committee is responsible for developing, prioritizing and maintaining a list of individuals who do not have either: • The functional capacity to make decisions regarding their own health or welfare; or • An existing LAR to make such a decision." Other responsibilities or requirements found in the policy include meeting regularly to discuss guardianship needs at the center and maintain meeting minutes that include: requests for guardianship services, the date of the meeting, members in attendance, items reviewed and decisions made. It was unclear whether the Guardianship Committee was expected to somehow act on requests for guardianship services, other than in developing and maintaining the prioritized list. The actual responsibilities of the Guardianship Committee should be clarified. The Monitoring Team commends the variety of educational activities on the part of the Facility and the HROs but would also like to reiterate the following: As part of the Facility undertaking an effective and appropriate large-scale effort to solicit guardians, the Facility should ensure it has an appropriate methodology in place to determine the actual need for guardianship as described above. DADS should provide guidance on such a	

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		methodology as soon as possible.	

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

1. DADS should ensure the final draft of the statewide DADS Policy on Guardianship is accompanied by adequate guidance to the PSTs in the area of assessment of decisional capacity in a manner that promotes and preserves individual rights to the maximum extent possible. This guidance should 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. (Provision U.1)
2. The Human Rights Committee should consider the informed consent restrictions with the same gravity afforded the other restrictions noted in the Rights Assessment. This may require provision of training to the committee members. (Provision U.1)
3. The Facility should either adhere to the criteria for prioritization described in either the statewide policy or the DSSLC version as written, or apply to DADS for a variance from the statewide policy and incorporate their actual process into the DSSLC version. (Provision U.1)
4. The Facility may want to consider whether the current composition of the Guardianship Committee adequately meets the intent of the statewide policy. Having a variety of perspectives in this area would appear to be a vital requirement. (Provision U.2)
5. The actual responsibilities of the Guardianship Committee should be clarified. (Provision U.2)
6. As part of the Facility undertaking an effective and appropriate large-scale effort to solicit guardians, the Facility should ensure it has an appropriate methodology in place to determine the actual need for guardianship**,** and for what areas of decision-making guardianship should be sought. (Provision U.2)

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. DSSLC Plan of Improvement (POI), dated 9/7/2011 2. DSSLC Presentation Book for Section V 3. DADS Policy 020.1 Recordkeeping Practices dated 03/05/10 4. DSSLC Policies and Procedures Manual Index 9/16/11 5. DSSLC Policy CMGMT-25 Recordkeeping Practices 5/18/10 6. DSSLC Policy ADM-01 Policies and Procedures Manual 3/1/10 7. DSSLC Policy CMGT-12.01 Personal Support Planning Process 1/3/11 and Exhibit to Policy: Pilot project Personal Focus Assessment and Facilitation 8/5/11 8. DSSLC Policy CMGMT-39 Most Integrated Setting Practices (State Office 018) 9/16/11 9. DSSLC Policy CMGMT-30 Guardianship 9/16/11 10. DSSLC Policy C7C-02 Quality Assurance/Quality Improvement Council 9/6/11 11. Section V report to QA/QI Council 5/19/11 and graphs of monitoring data for April, May, June 2011 12. Graphs of monitoring data for July 2011 13. Active Record Order & Guidelines (AROG) revised 6/22/11 14. Master Record Purging Schedule (8/10/11) 15. Individual Notebook & Guidelines revised 3/17/11 16. Active Record, Master Record, and Individual Notebook for Individuals #205 and #551, and Active Record for Individual #469 17. Individual Notebook for Individual #119 18. Records Audits and emails listing corrective actions required for June, July, August, and September 2011 for Individuals #4, #11, #28, #91, #205, #224, #276, #295, #394, #452, #489, #528, #554, #650, #703, #705, and #768, and for May 2011 for Individual #292 19. Settlement Agreement Cross Referenced with ICF-MR Standards 12/2/10 and Guidelines for scoring 20. Audit completed by the Unified Record Coordinator (URC) for Individual #205 21. Settlement Agreement Provision V.4—Interview Tool for use of the Record Revised April 2011 22. Records Clerks Meeting Minutes 3/1/11 and 4/13/11 documenting training and discussion on records audits 23. Record Clerk Meeting Minutes 6/5/11 with attached class description on Filing Priority Documents and sign-in sheets 24. Sign-in sheets for training on use of check-out cards for records 25. Memo from Melissia Steele to Medical Staff regarding "Gaps" in documentation, dated 5/10/11 26. Emails from Wes Knox to Melissia Steele with list of randomly assigned audits for August and September 2011 27. Cedar Falls Coordination Delinquency List 9/7/11 28. Example of assessment deficiency list 8/24/11 **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. DCPs at 507A 6. Joint interview of QDDPs Marquita Greer and Marty Mapp **Meeting Attended/Observations:** 1. PSP Annual Planning Meeting for Individual #373
	Facility Self-Assessment: The Facility reported that it was in compliance with Provision V.3 but was not yet in compliance with the other provisions of this Section. The Monitoring found that none of the provisions of this Section are yet in compliance, although significant progress has been made. With a few exceptions, the current POI simply reported on actions taken, rather than evaluating whether the actions taken are producing the desired outcomes, and why or why not. The POI did not provide many details as to the Facility's self-assessment processes, but rather listed actions the Facility had taken since the last visit and, in some cases, provided a list of Action Steps and completion status. The Facility should consider how it may more fully use its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes. For example, as noted below, the Facility stated for Provision V.1 that "the monitoring tool data indicates 100% compliance with this provision for the last quarter (April, May, and June 2011)" but the records audits completed in May 2011 and June 2011 reviewed by the Monitoring Team did not find full compliance; review of trend data provided to the QA/QI Council showed that the Facility actually reported that 100% of individuals had a Unified Record (which the Monitoring Team confirmed) but not that other Appendix D requirements were met. Furthermore, trending data provided in the self-assessment for Provision V.3 also show lack of compliance with Appendix D requirements. A positive note is that the self-assessment did include some data (such as the trending information ins Provision V.3) that could be used by the Facility in reporting its status; in the current self-assessment, it was reported, but no analysis was provided.
	Summary of Monitor's Assessment: The Facility maintained a unified record for each individual. The unified record at DSSLC consisted of an Active Record, Master Record, and an Individual Notebook. Recordkeeping was improved from the last compliance visit. The Active Records were more generally complete and legible. Nevertheless, continued improvement is needed. No Active Records met all requirements of Appendix D, although they continue to improve. Records were generally but not always accessible. However, the Facility needs also to ensure that records are secure and can only be accessed by people who are authorized to view them. 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 to audit records was nearing compliance. There was now a process to select records randomly for audit. Both records clerks and the URC audited the same records, and the database into which the findings were entered could be used to calculate inter-rater agreement but that had not been done. Corrective actions for individual records were routinely identified, and the URC checked each record to ensure corrections were completed. There were examples of actions taken to correct systemic issues, but there was no process in place to review the effect of those actions. The Facility had initiated processes to monitor and evaluate how records are being used. These included checking the Share Drive to determine what assessments were not posted timely, interviewing staff about their use of the records, and reviewing the IPNs to determine whether multiple disciplines made entries. Nevertheless, there were examples in which information in the record should have led to actions, but there was not an indication that this information was used to make decisions. DADS and the Facility had developed or revised policies since the last compliance visit. New and revised policies addressed a number of medical and dental care issues, incident management, quality assurance and improvement, and psychological and behavioral services. The Facility had revised policies on most integrated setting and guardianship, and was awaiting finalization of DADS policies in those areas. Although no provision of this Section was in compliance, progress continued, and provisions are approaching compliance.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	The Facility maintained a unified record for each individual. The unified record at DSSLC consisted of an Active Record, Master Record, and an Individual Notebook. The Active Record was the primary document with information about the individual's current status and about the supports and services being provided. The Individual Notebook contained information needed by people providing daily service and held the PSP, PNMP, instructions for providing supports and services, and current forms for recording health status and data on skill acquisition and behavioral programs. When documents are purged from the Active Record, they are to be sent to Central Records to be place in the Master Record; the Master Record also contains other documents, such as legal documents including birth certificate and guardianship papers. In addition, assessments and some other information were copied to a shared drive that was not considered part of the unified record but allowed information to be easily accessible to members of the PST. Recordkeeping was to follow DSSLC Policy CMGMT-25 Recordkeeping Practices. This policy operationalized to the Facility the DADS Recordkeeping Practices policy. It had	Noncompliance

#	Provision	Assessment of Status	Compliance
		added information on use of a Check-Out Card to track the record whenever it had to be removed from its normal location; this helped ensure records were accessible when needed. It also added information on what identifying information needed to be on each page of the record, provided examples of inaccurate information and what should be done if inaccurate information is discovered in the record, and made the Unit Director for an individual responsible for completing requirements for filing in the absence of the unit Records Clerk. Active Records were filed in two, three, four, or (for some individuals with complex medical conditions) five binders, depending on the amount of documents involved. An Active Record Order & Guidelines listed the order of documents and the maintenance guidelines that stated how long each document should remain in the Active Record; this was filed in the front of every binder. Recordkeeping was improved from the last compliance visit. The Active Records were more generally complete and legible. Nevertheless, continued improvement is needed. Since the last compliance review, the clinical records were better organized and more accessible. To determine whether Active Records were completed in compliance with Facility expectations and Appendix D of the SA, the Monitoring Team reviewed the complete Active Record, Master Record, and Individual Notebook for Individuals #205 and #551, and Active Record and Individual Notebook for Individual #469. This sample was selected to include the individual who was admitted to the Facility since the last compliance visit, one individual whose record was being audited by the Facility in September (randomly selected by computer from the records being audited), and one individual selected without any special criteria. Although records were generally in order and, for the most part, complete and legible, none of the Active and Individual records met all the requirements of Appendix D or of Facility policy. For the Active Record, the Monitoring Team checked for the presence of each applicable item on the Active Record Order & Guidelines. Many documents are not applicable in every record. For items that could have many pages or documents (for example, Observation Notes or SPOs), the item was marked not present if the Monitoring Team identified missing documents. The Monitoring Team made an effort through review of other documents in the record to determine whether each document, if not in the record, was applicable. For example, if an individual had in the record an action plan with a specific learning goal, there would be	

#	Provision	Assessment of Status	Compliance
		an expectation that a matching Specific Program Objective would be in the appropriate section of the record. Findings on percent of required documents in the records reviewed showed, for the documents determined by the Monitoring Team to be applicable: • For Individual #205, 92% of applicable documents were present. • For Individual #469, 93% of applicable documents were present. • For Individual #551, 92% of applicable documents were present. Some consistent concerns were found in the sampled records: • For one of three (33%) all documents were legible. • Zero of three (0%) contained all required documents. • Zero of three (0%) were completely accurate • For one of three (33%) all documents were current. • For zero of three (0%) the record was consistent with the table of contents. All records requested by members of the Monitoring Team were available, indicating that each individual has an Active Record. Observations in homes found both Active Records and Individual Notebooks to be accessible. The Monitoring Team visited 507A, the home of Individual #119, and requested the Individual Notebook. DCPs at 507A readily accessed the Individual Notebook for Individual #119 and showed where to find the PNMP. They stated they use the Individual Notebook to enter data and Observation Notes but can find the PSP, PNMP, and behavioral information. They stated that training objectives (TDRs) and behavior plans are found also in a separate book at the day program site. Although records are accessible in the homes, they are not secure. At both 507A and 504A, Individual Notebooks were kept in boxes on the floor. At 504A, when no individuals or staff were at the home (and the door to the home was unlocked), the Monitoring Team found the Individual Notebooks in the box next to the door. The Facility needs to ensure Individual Notebooks cannot be easily accessed by people who are not authorized to view them. Not all needed information was always accessible. For example, the PNMP was located in the individual notebook that followed the person; however individuals not residing on Houston Park or Cedar Falls did not have their books follow them and therefore the PNMPs were not readily available to staff. At no time during any of the observations was staff observed referring to the PNMPs, and no evidence was observed that the PNMP was found in any other book at the sites where these individuals received services.	

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		Other monitoring activities found specific documents missing. • The Medication Administration Records were reviewed for Individuals #580, #217, and #349. The nurses' signature sheets did not contain the signatures and initials for all for the nurses' names printed on the sheets. • In clinical records of Individuals #83, #310, #4, and #690, the Monitoring Team could not identify an updated dental summary, nor did the Annual PSP reflect specific supports and services needed for dental services. Additional issues were identified through Monitoring Team review: • Integrated Progress Notes (IPNs) did not consistently include the time the notes were written. • Handwriting legibility continued to be poor in IPNs. • A consult report for Individual #530 was found in the active record for Individual #336 Although the Monitoring Team understands that there is no way to prevent occasional errors in such a large number of records, and the percent of applicable documents in the sampled records was relatively high, the presence of systemic issues indicates the audit process has not been in place long enough to ensure that records are compliant with standards. Furthermore, the Facility needs to ensure records are both accessible and secure. For both individuals for whom the Monitoring Team checked the Master Record (Individuals #205 and #551), the Master Record was available. The Master Record is divided into categories. The Facility did not determine whether all documents that should have been purged have actually been purged and sent to Central Records. Although not considered by the Facility to be part of the Unified Record, the Share drive provided the potential for accessibility to assessments by all members of the PST. The Personal Support Plan Policy III.D requires PST members to file their assessments and recommendations on the Share drive 10 days prior to the PSP meeting, and requires PST members to review all assessments "to prepare for a comprehensive, integrated discussion during the PSP meeting." QDDPs provided the Monitoring Team, through interview on 9/19/11, with a description of the process for posting and accessing assessments. The QDDP reviews the Share drive folder for the individual 10 days prior to the annual PSP planning meeting both to determine which assessments have and have not been posted and to gather information from the assessments to use in planning the PSP and identifying issues to be covered during the risk assessment review. If assessments are missing, the QDDP sends an email to the responsible person. The QDDP may request additional information or clarification as needed. The folder was opened for	

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		Individual #373, whose PSP was to be held 9/21/11, two days later. Of 14 required assessments, nine (64%) were present. Of these nine, six had been posted 10 days in advance of the PSP meeting (that is six of 14 required assessments, or 43%, were posted 10 days in advance, as required by policy). The Facility had a process to monitor whether assessments were posted in advance of the PSP meetings; the data were based on the percent of all assessments on the list of possible assessments, not on the assessments the QDDP identifies as required for a specific individual. The Monitoring Team reviewed the available PSP assessments for seven individuals who had PSP meetings during the week of the site visits or PSP meetings scheduled to occur within ten days following the site visit. For zero of seven individuals (0%) were all of the required assessments available in the O drive as required by policy. The Facility needs to identify the assessments required by policy for everyone and develop a process to track posting of those and of the additional assessments assigned by the QDDP for the individual. The Share Drive also had other uses. To improve accessibility of information for use by clinicians, many documents that are found in the Active Record are also posted to the Share Drive, including PSPs, PSPAs, and TDRs. This is an excellent tool for making information easily accessible to clinicians and increasing efficiency of their work. Given the improvement in records, the Monitoring Team expects that continuation of the auditing processes described in Provision V3 has the potential to bring this provision into compliance in the near future.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	As is discussed throughout this report, policies and procedures necessary to implement the Settlement Agreement were in various stages of development. This included policies that DADS State Office was developing, as well as those being developed or revised at the Facility level. Lori Powell, Director of Quality Assurance (QA), described the Facility's process to develop or revise policies. The Facility assigns each policy a primary and secondary coordinator; these staff work together to draft new policies and revisions, which are sent to the Executive Management team and other relevant staff for input. The primary coordinator saves these drafts to a shared drive and notifies the Director of QA, who checks the draft for consistency with requirements (such as that dates are included and are accurate). After receiving input, the coordinators prepare a final draft and notify the Facility Director for approval. When a policy is reviewed, it is sent to all users to replace or add to the policy book and is put in the M Drive Approved Policies folder. At that time, also, all Executive Management team members are inserviced. They are then responsible to train staff on policies. For some major policies that have significant change, campus-wide training will be provided, and CTD may provide annual refresher training; for those, sign-in sheets will be retained. The Facility did not have a way to verify training done by	Noncompliance

#	Provision	Assessment of Status	Compliance
		departments. DADS has developed and distributed draft policies on Most Integrated Setting (draft DADS policy operationalized in the DSSLC Policy and Procedures Manual as CMGMT-39) and Guardianship (included with some local operationalization as CMGMT-30). Both Facility policies had been implemented too recently for the Monitoring Team to review adequacy of implementation. These policies were put into the facility policy manual with little or no operationalization. For example: • In the policy on Most Integrated Setting, under Assisting Individuals with Movement to the Most Integrated Setting paragraph A.5, there is a statement that the "State Center will afford each individual to opportunity to participate in tours of community provider homes, day programs, and employment opportunities. Tours will be facilitated by the State Center and scheduled in conjunction with the local MRA." Although the policy assigns the State Center APC to document tour participation, it does not assign responsibility to specific Facility staff for any of the actions involved in providing opportunities for tours or arranging the tours. As this might differ from one State Center to another, it is important for each facility to clarify that in its facility policy. • The DADS statewide draft policy on Guardianship establishes a Guardianship Committee; the Facility policy states "DSSLC must have a Guardianship Committee…" thereby modifying the DADS policy to refer to DSSLC; however, it does not state how members are appointed to the committee (which may differ from one State Center to another) or who is responsible for developing and providing training to committee members. Furthermore, the policy states that "DSSLC' Human Rights Officer serves as the Guardianship Coordinator"; the DSSLC organization chart provided to the Monitoring Team lists two Human Rights Officers, and the policy does not indicate which will serve in this role or who will make the assignment of one to this role. When the draft policies are finalized and implemented, there would be an expectation that the Facility would also revise local policy to match and to clarify any facility-specific procedures. The Facility had developed or revised numerous policies since the last compliance visit. In addition to the policies described above, new and revised policies relevant to implementation of this SA included: • Medical 06 Life Threatening Emergency Situations • Medical 08 Life Sustaining Treatment • Medical 11 Major Dental Procedures • Comms/Councils 05 QA-QI Council	

#	Provision	Assessment of Status	Compliance
		• Comms/Councils 23 Medication Variance Review Committee • CMGMT 01B Incident Management • CMGMT 13 Determination of Levels of Supervision • CMGMT 21 Dental/Medical Sedation and Restraint • CMGMT 24 Psychological Services • CMGMT 26 Behavior Services Counseling Policy and Procedure The Monitoring Team asked for the following documentation: "For each such policy, a copy of communication to staff to inform them of the policy, a description of training provided (with a copy of training materials), and/or blank competency evaluation tools.' In response, the Facility stated "the Center Director sends out an email to all email users at the facility notifying of updated/new policy." Standard language of the email provided to the Monitoring Team indicated that the email simply told the email users to file hard copies and to distribute the policy widely. No information on training was provided to the Monitoring Team; the Monitoring Team was not given sign-in sheets or any other evidence that campus-wide training was done, nor was any evidence of department training provided. Although training may not be needed when there are minor revisions in policies, training may be essential when there are significant revisions or new policies that require changes in procedures (for example, procedures for PST consideration of guardianship or of most integrated settings). It is essential that the Facility document training provided on sensitive or essential policies. In general, the Monitoring Team found improvement in implementation of policies. Nevertheless, there remained examples in which policies had been developed (in some cases, recently) but were not fully implemented. For example: • The Dental/Medical Sedation and Restraint 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 did not find a Restraint Checklist in any of the 22 restraint files included in the sample. • Assessments were not posted timely in the Share Drive as required by the Facility PSP policy. • The Facility developed an excellent policy for pharmacy to monitor Metabolic Syndrome. At the time of this review, however, the policy had not been implemented. • DADS and Facility policy required that the CLDP be reviewed with the individual and LAR at specified intervals throughout the CLDP process and documented as these occurred. The Facility was unable to provide evidence of these ongoing reviews as required.	

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		Some essential policies still need to be completed. • The draft DADS policies described in this section need to be finalized and implemented. • The Facility needs to complete development of its PNMP policy. Much progress has been made in development and implementation of policies needed to implement the requirements of the SA. The Monitoring Team expects that progress to continue.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	The Facility had a process in place to audit five randomly selected records each month. This process had changed since the last compliance visit. At that time, each records clerk audited one record per month from a sister unit, and the URC audited five records (four of which were inter-rater reliability checks of records audited by one of the records clerks). Records were not selected randomly at that time. This process was changed to provide random selection of five individuals whose records are to be audited; the data management department provides a list selected by computer of five individuals across the whole Facility. The records clerk for a sister unit audits the record and enters the ratings into a database. The URC also audits all five records. These audits were not done at the same time, so level of agreement could be affected by corrections made in between audits. It would be better if the records clerk and URC could audit within a short time period before corrective actions are taken; nevertheless, this procedure can provide valuable information about the accuracy of audits and the clarity of the audit tool and definitions. The records clerk and URC did audits independently. The URC reported that, following audits, she retrained records clerks as needed and identified items she might have missed. However, inter-rater agreement was not calculated, so there was no evidence that the audit tool and definitions provided accurate data. The Director of Quality Assurance indicated inter-rater agreement could be calculated by computer from the database, and the Monitoring Team recommends this be done. The Monitoring Team audited the record for Individual #205 immediately following audit by the URC. Agreement was calculated both for the monitoring tool (Settlement Agreement Cross Reference with ICF-MR Standards) and the Active Record Order and Guidelines (which was the table of contents of the Active Record and served as a source document for completing the monitoring tool). The AROG contained 96 items that either the Monitoring Team, the URC, or both found to be applicable; of those, the two raters agreed on presence or absence of 72 items, for a 75% agreement. This agreement is slightly lower than the 80% agreement that is typically accepted as evidence of acceptable definition. Agreement on the monitoring tool items was also 75%. For compliance, the Facility should provide data on agreement over time between the audits by URC and the records clerks while continuing to use the current independent audit	Noncompliance

#	Provision	Assessment of Status	Compliance
		process and should document any changes in definitions or any retraining that results from findings regarding agreement. The Facility reported this process for corrective action following audits: • Once audit is completed, the Unified Records Coordinator (URC) sends an email of the findings and corrective actions needed to the appropriate people. • Corrections are to be made within 5 business days. • Around the 5th business day, the URC re-checks the record and updates findings. • If still not corrected, then 24 hours is given to make the needed corrections. • The next day the URC re-checks the record again and if still not corrected the Assistant Director of Programs is notified. The Monitoring Team reviewed corrective action emails for all audits done in June and July 2011. All had documentation of notice of deficiencies and corrections needed. All had a statement from the URC that deficiencies that could be corrected were cleared. Several had additional emails prior to clearance indicating that the URC found, while checking corrections, that not all corrections had yet been completed and identified what more was needed. This process, that has review of the record by the URC to confirm that corrections have been made, ensures that corrective actions are completed. The Facility reviewed findings of the audits at the QA/QI Council meetings. Trend data for January through July 2011 showed that overall compliance declined between February and March and then remained stable. The overall compliance average for all items on the tool was approximately 75% for the seven-month period. The trending data for May, June, and July 2011 was broken out for certain items. Presence of all three components of the Unified Record was reported for all records audited. Meeting all Appendix D requirements was 59.8% in May, 71.8% in April, and 70% in June 2011. Actions were taken as a result of review of audits and trends. Examples include: • One issue found was that there were gaps in the records. The URC sent a memo to medical staff on 5/10/11 that provided instructions on completing pages so that there would be no gaps. The Monitoring Team was informed that the Facility had not examined data on the results of the memo. The QA Coordinator was quickly able to access data on this item in the audits and found no improvement in June and July 2011 compared to April and May 2011. When implementing corrective actions, the Facility needs to follow up to determine effectiveness and to continue corrections until the identified issue is resolved. • The use of Check-out Cards was implemented in order to carry out requirements of the Recordkeeping policy and to ensure records could be located. Training was provided to direct service staff.	

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		In addition, the Facility sends weekly to clinicians, supervisors, and administration a list of all assessments due in the Share Drive but not posted. The audit process is very close to being compliant with the requirements of this provision. The Facility will need to ensure that the tools and definitions permit accurate rating; this can be demonstrated through calculating and tracking inter-rater agreement. The Facility also needs to ensure the effect of systemic corrective actions is tracked so that the records can meet the requirements of Appendix D.	
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 had initiated processes to monitor and evaluate how records are being used. One such process is the deficiency list noted in Provision V3 of assessments due on the Share Drive but not posted. Unless assessments are posted, they cannot be reviewed easily by all PST members. Although this deficiency list does not indicate who has viewed the assessments, it does indicate what is available for viewing and for using in making decisions about care, treatment, and training. Another process is an interview of PSTs using a standard format. The URC selected one individual per month from the audited records. For that individual, she asked staff from the individual's PST (in a face-to-face interview) a set of questions on the Settlement Agreement Provision V.4— Interview Tool for use of the Record. The questions ask for an example of how the PST member used information from the record in making a decision about the individual and an example of how a report from another discipline helped the PST member plan a treatment or intervention, how the record is used in meetings, whether documents can be found, and how the PST member ensures staff in his/her department or discipline use information from the record in making decisions. For each PST member, the interviewer rates whether the answers do or do not indicate the record is used in making decisions. From that information, the URC made a finding of whether the PST used the information in the record. There was no process in place to assess interobserver agreement on the ratings or to track and trend any of this information. Nevertheless, this is a promising approach that could be extremely useful if the information is provided and acted on by department heads, unit coordinators, and others who could use it to coach staff. The Facility provided an example of the interview from May 2011; the individual whose team was interviewed was not identified; some staff were identified by name and others only by discipline. All staff Interviewed stated they use the record and gave one or more examples of reports from other disciplines that help them plan a treatment or intervention. They indicated they could find documents most of the time, but some that was not always the case.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The Monitoring Team also did a number of interviews asking the same questions. However, these interviews asked the questions in general rather than specific to an individual, and some interviews were in groups. Recognizing that some of the 11 Monitoring Team interviews included information from up to three individuals, the following was reported: • Two (18%) reported documents could be found, four (36%) reported documents could be found usually or most of the time, two (18%) reported that sometimes documents could not be found, and three (17%) reported documents could not always be found. Note the overlap; because these are narrative responses, it can be difficult to categorize them. For the Facility to trend this information, it will be important to define categories of responses and to determine inter-rater agreement on categorization of the responses. • All (100%) identified a way in which they used the record when making decisions. Many were very general in their statements. • Ten of 11 (91%) identified a report from another discipline that helped in planning a treatment or intervention In addition, the URC reviewed the IPNs for an audited individual; if more than five disciplines wrote in the IPN during the prior six months, the URC recorded that as an indication the record was being used. These data were presented to the QA/QI Council; for May, June, and July 2011, there was an increasing trend of 55.6% in May, 85.7% in June, and 100% in July. Nevertheless, the Monitoring Team found examples in which information in the record was not used when making decisions. For example: • For zero of seven (0%) of individuals who had PSP meetings during the week of the site visits or PSP meetings scheduled to occur within ten days following the site visit, all of the required assessments were available in the O drive as required by policy. • For Individual #54, a skill acquisition program written in April 2010 had continued unrevised for 17 months. A review of the data reflected mastery of the skill occurred several months prior to the site visit. There was no indication the program was being considered as having met completion. • For Individual #61, it was identified in last year's PSP that the team would provide supports for the individual to visit an elderly mother and niece at least once per month. No visits were made during the entire year, nor was any documentation made as to this support. Neither the QDDP nor other PST members noted that the record did not indicate the support in the PSP was not provided, nor did this lack prompt action. The Facility is approaching compliance with this provision. The processes in place are a	

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		good step toward compliance. The Facility needs to continue to implement these processes and also ensure that PST members review assessments, data, and other information from the Unified Record to make timely and appropriate decisions.	

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

1. Ensure Individual Notebooks cannot be easily accessed by people who are not authorized to view them. (Provision V.1)
2. The Facility should document training provided on sensitive or essential policies. (Provision V.2)
3. Inter-rater agreement should be calculated and tracked for the records audits. It would be best if both the records clerk and the URC audited the records at about the same time, before changes could be made in the record. (Provision V.3)
4. Identify the assessments required by policy for everyone and develop a process to track posting of those and of the additional assessments assigned by the QDDP for the individual. (Provisions V.1 and V.3)

List of Acronyms

Denton State Supported Living Center

September, 2011 Compliance Visit

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACP	Acute Care Plan
ADOP	Assistant Director of Programs
ACP	Acute Care Plan
ADL	Activity of Daily Living
ADR	Adverse Drug Reaction
AED	Anti-Epileptic Drug/Automated External Defibrillator
AFO	Ankle Foot Orthotic
AIMS	Abnormal Involuntary Movement Scale
ANA	American Nurses Association
A/N/E	Abuse/Neglect/Exploitation
AP	Alleged Perpetrator
APC	Admissions/Placement Coordinator
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
AROG	Active Record Order & Guidelines
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BP	Blood Pressure
BSP	Behavior Support Plan
BSRC	Behavior Support Review Committee
CAP	Corrective Action Plan
CBC	Criminal Background Check
CDC	Centers for Disease Control and Prevention
C-Diff	Clostridium Difficile
CLDP	Community Living Discharge Plan
CLO	Community Living Options
CLODR	Community Living Options Discussion Record
CLOIP	Community Living Options Information Process
CMS	Centers for Medicare and Medicaid Services
CEU	Continuing Education Unit
CNE	Chief Nurse Executive
COP	ICF/MR Condition of Participation
CPR	Cardiopulmonary Resuscitation

CRIPA	Civil Rights of Institutionalized Persons Act
CSO	Campus Supervision Overnight
CTD	Competency Training and Development
CV	Curriculum vitae (resume)
CWS	Client Work Station
DADS	Texas Department of Aging and Disability Services
DCP	Direct Care Professional
DD	Developmental Disabilities
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DMID	Diagnostic Manual-Intellectual Disability
DNR	Do Not Resuscitate
DOJ	U.S. Department of Justice
DRO	Differential Reinforcement of Other Behavior
DRR	Drug Regiment Review
DSHS	Department of State Health Services
DSM/DSM IV TR	Diagnostic and Statistical Manual of the American Psychiatric Association
DUE	Drug Utilization Evaluation
EEG	Electroencephalogram
EKG	Electrocardiogram
ER	Emergency Room
FA	Functional Analysis or Functional Assessment
FBA	Functional Behavior Analysis or Functional Behavior Assessment
FFAD	Face-to-Face Assessment/Debriefing
FSA	Functional Skills Assessment
FSPI	Facility Support Performance Indicator
FTE	Full Time Equivalent
FY	Fiscal Year
GERD	Gastroesophageal reflux disease
HCG	Health Care Guidelines
HCP	Health Care Plan
HIPAA	Health Information Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMP	Health Maintenance Plan
HOB/HOBE	Head of Bed/Head of Bed Elevation
HRC	Human rights committee
HRO	Human Rights Officer
HST	Health Support Team
HT	Habilitation Therapy
IBW	Ideal Body Weight
IC	Infection Control
ICF/MR	Intermediate Care Facility for the Mentally Retarded

ICF/DD	Intermediate Care Facility for Persons with Developmental Disabilities
ID/DD	Intellectual Disability/Developmental Disability
IDT	Interdisciplinary Team
IED	Intermittent Explosive Disorder
IMC	Incident Management Committee
IMRT	Incident Management Review Team
IPN	Integrated Progress Note
ISP	Individual Support Plan
i.v./IV	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
MP	Medication Plan
MR	Mental Retardation
MRA	Mental Retardation Authority
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus Aureus
NA	Not Applicable
NANDA	North American Nursing Diagnosis Association
NCP	Nursing Care Plan
NDC	Non Direct Care
NEO	New Employee Orientation
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NP	Nurse Practitioner
O2	Oxygen
O2Sat	Oxygen saturation
OCD	Obsessive Compulsive Disorder
OIG	Office of the Inspector General
OJT	On the Job Training
OT	Occupational Therapy
OT/OTR	Occupational Therapist, Registered
PALS	Positive Adaptive Living Survey
PAO	Physical Aggression toward Others
P&P	Policies and Procedures
P&TC	Pharmacy and Therapeutics 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
PFI	Personal Focus Interview
PIC	Performance Improvement Council
PMAB	Physical Management of Aggressive Behavior
PMOC	Psychiatric Medication Oversight Committee
PMR	Psychiatric Medication Review
PMT	Psychotropic Medication
PNA	Psychiatric Nursing Assistant
PNM	Physical and Nutritional Management
PNMC/PNMPC	Physical and Nutritional Management Coordinator/ Physical and Nutritional Management Plan Coordinator
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PO	By mouth, oral intake
POC	Plan of Correction
POI	Plan of Improvement
PRC	Polypharmacy Review Committee
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/Physical Therapist
PTR	Psychiatric Treatment Review
QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QI	Quality Improvement
QMRP/QDDP	Qualified Mental Retardation Professional/Qualified Developmental Disabilities Professional
QPR	Quarterly Psychiatric Review
RD	Registered Dietician
RN	Registered Nurse
r/o	Rule out
ROM	Range of Motion
SA	Settlement Agreement
SAC	Settlement Agreement Coordinator
SAM	Self-Administration of Medication
SAN	Settlement Agreement for Nursing
SFBA	Structural and Functional Behavior Assessment
SIB	Self-injurious Behavior

SLP	Speech and Language Pathologist
SO	State Office
SOAP	Subjective, Objective, Assessment/Analysis, and Plan charting method
SSLC	State Supported Living Center
SPCI	Safety Plan Crisis Intervention
SPO	Specific Program Objective
SQRA	Standard of Quality for Risk Assessment
SSLC	State Supported Living Center
SSO	Staff Service Objective/Specific Service Objective
STAT	Immediate
STD	Sexually Transmitted Disease
TB	Tuberculosis
TD	Tardive Dyskinesia
TIVA	Total Intravenous Anesthesia
UA	Urinalysis
UIR	Unusual Incident Review or Unusual Incident Report
UTI	Urinary Tract Infection
VCF	Virtual Client Folder
VDB	Verbally Disruptive Behavior
VNS	Vagal Nerve Stimulator
VRE	Vancomycin-resistant enterococcus
x/o	Rule out