United States v. State of Texas

Monitoring Team Report

Denton State Supported Living Center
April 2-6, 2012

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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.

Substantial Compliance Ratings and Progress

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

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

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

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

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

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

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, Mary Ramos, and the staff who assisted her to keep up with all our requests, especially Angie Alejo, Myrna Wolfe, Claudia Lucio, Jessica Juarez, and Rosie Sanchez. They ensured the documents requested were available before, during, and after the visit. They coordinated arrangements for all the meetings and observations. Too many other staff to mention assisted in numerous ways.

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. The following report provides brief highlights of areas in which the Facility is doing well or had made significant improvements and other areas in which improvements are needed.

[Provide an overview of the findings, progress and/or areas of concern and recommendations.]

General Comments

Population. Population of the Facility at the beginning of the compliance visit was 504 individuals.

Facility Self-Assessment. DSSLC wrote its self-assessment following new guidelines from DADS. As indicated in each of the sections of the report below, this was a good first step. Overall, the new format should help guide the facility in moving forward and to help managers and clinicians develop the ways in which they assess the quality and depth of the activities in which they and their staff engage to meet the many items of each of the provisions of the Settlement Agreement. The self-assessment described the activities engaged in to assess status, results (in some cases including data on status of processes or on outcomes), and the self-rating and rationale for the rating. The Monitoring Team provides, in this report, many specific reviews of the self-assessments to assist the Facility to select appropriate activities and measures of status and to describe reasons for discrepancies in ratings between this report and the self-assessment. The Facility should consider how it might expand use of its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes.

In addition, DSSLC provided for each Section of the Settlement Agreement provisions an Action Plan listing actions to be taken to move forward toward compliance. This report also provides some comments about the action steps in order to assist the Facility to review its plans and ensure they will lead toward compliance and will provide an organized approach that can coordinate with the self-assessment.

Specific Findings

Following are summaries of specific findings for each Section of the Settlement Agreement:

Restraints

Policies, procedure, and documentation systems for restraint use 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 primary obstacle to achieving compliance with Section C of the SA remains deficient practices and documentation associated with medical restraint.

- Positive Practices and Improvements Made
    - DSSLC's policies that govern restraint appear sufficient, if consistently applied, to achieve compliance with the SA.
    - With the exception of three individuals who had Safety Plans for Crisis Intervention and had special circumstances associated with their treatment plans, the frequency of use of crisis intervention restraint had steadily decreased.
    - No individuals were subjected to emergency chemical restraint since the last review.

- The Facility's restraint review practices were thorough, comprehensive, and effective in identifying factors which needed to be addressed to minimize the need for future use of restraint with the particular individual subject to review.

- Improvements Needed
  - Individual Support Plans (ISPs) for individuals for whom medical restraints were used for routine medical or dental care did not include treatments or strategies to minimize or eliminate the need for restraint.
  - The sections of the Annual Physician Summary intended to document restrictions or limitations on the use of restraint were overly general.
  - Many records of medical restraint use did not include documentation required by policy.

<u>Abuse, Neglect and Incident Management</u>
The Facility was found to be in substantial compliance with 12 Provisions/components of Provision requirements in the Settlement Agreement and does many things well.

- Positive Practices and Improvements Made
  - The Facility demonstrated 100% compliance with the staff training requirements associated with abuse, neglect, and exploitation, and unusual incidents. Additionally, staff tested by the Monitoring Team had retained the knowledge learned in class.
  - Reporting procedures were prominently displayed throughout the Facility and are printed on the back side of employee identification badges.
  - In every instance where an alleged perpetrator (AP) was known the AP was immediately placed in no direct contact status.
  - The Monitoring Team did not discover any instance of a mandatory reporter failing to report abuse or neglect.
  - Law enforcement notification occurred for all sampled allegations of physical abuse.
  - Compliance with required background checks was confirmed.

- Improvements Needed
  - Several instances of late reporting of allegations were noted.
  - Processes in place to review discovered injuries, including non-serious injuries, were not sufficient to ensure all instances of possible abuse or neglect are discovered and reported.
  - The training transcript for one DFPS investigator did not document completion of required training.
  - Investigations sampled by the Monitoring Team were not always adequately initiated with 24 hours of the report of the incident.

- DFPS and Facility investigation reports reviewed were not always sufficient in scope and depth to provide a clear basis for investigation conclusions.

Quality Assurance

The work effort observed during this monitoring visit demonstrated continued improvement in the development and implementation of an effective QA system.

- Positive Practices and Improvements Made
  - The Monitoring Team commends the Facility for revising trend data to include longitudinal data.
  - The Facility is to be commended for incorporating key indicator data in its QA process. Data affecting the key indicators is also reviewed in the QA/QI Council. These included a variety of good metrics from which organizational performance (and SA compliance) can be measured.
  - The Facility had put in place an organized and operational system for the development, implementation, and tracking of corrective action plans (CAPs). Implementation was still limited at the time of the visit.
- Improvements Needed.
  - It did not appear the process for inter-rater reliability had made much progress since the last review.
  - The Facility was unable to describe any process to determine if a CAP was effective in remedying or reducing the problems originally identified.
  - There was no 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.
  - The Facility QA process did not appear to be using available data to identify individuals with concerns across multiple areas (e.g., injuries, incidents, hospitalizations or ER visits, restraints, etc.), and use these data to identify possible systemic issues.

Integrated Protections, Services, Treatments and Supports

Overall, the Facility's progress had not been substantial in developing and implementing 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, although some improvements were identified. A summary of progress noted included some improvements in assessment processes across various disciplines; while this was not universal, nor was it always substantial, it was indicative of a positive direction.

- Positive Practices and Improvements Made
  - Staff attendance at ISP meetings showed considerable improvement.
  - The Facility continued to implement the "Supporting Visions" ISP process, which was intended to reinforce the concept that planning is intended to support the individuals' vision for the future.

- The Facility continued to devote considerable resources to training, monitoring, and coaching for QDDPs.

- Improvements Needed
  - Although considerable training had been provided QDDPs, only four had been certified as competent in ISP facilitation skills.
  - DSSLC had undertaken some initiatives to improve the timeliness and strengthen the quality of its assessment practices. These had met with limited success thus far. IDTs often failed to conduct comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs.
  - ISPs still 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.
  - ISP strategies did not reflect encouragement of community participation in any meaningful or purposeful manner.

Integrated Clinical Services

The Facility has continued to expand steps toward providing clinical services in an integrated manner.

- Positive Practices and Improvements Made
  - The Facility implemented policy that, while it provides few expectations or procedures, it makes clear the expectation of integrated services**.**
  - Participation across disciplines had increased in both IDT meetings and committees and workgroups working on systemic improvements.
  - The Facility implemented a new medical consultant report form with a back page for documentation of review and response to recommendations; documentation was to go there and in the IPN.
- Improvements Needed
  - Planning of services and supports did not consistently indicate collaborative joint planning.
  - Physicians consistently documented review on the consultation forms (although some dates were not provided) but not consistently in the IPN.

Minimum Common Elements of Clinical Care

The Facility had taken significant steps to develop clinical indicators and other processes that have great promise. At the same time, assessments continue not to be consistently timely or of adequate quality. The Facility will need to work assertively to turn potential into actual improvement in services.

- Positive Practices and Improvements Made
    - Diagnoses were consistent with ICD-9 and DSM IV codes.
    - The Facility had developed a set of clinical indicators that could be used to assess efficacy of treatments and interventions. The databases permitted these indicators to be tracked and reported facility-wide, by units, and by individuals.

- Improvements Needed
    - There had been improvements in both timeliness and comprehensiveness of some assessments, but problems remained regarding adequacy of assessments and evaluations, and provision of evaluations in response to changes in an individual's status.
    - Assessments for the ISP were often not completed on a timely basis.
    - Although assessments were now being done consistently following hospitalization for a PNM issue, there were still many examples in which assessments were not updated when there was a change in health status.
    - Psychiatric evaluations did not always document clearly the rationale for the diagnoses or which symptoms were consistent with the diagnosis.

<u>At-Risk Individuals</u>

The Facility continues to put effort into improving risk assessment and planning to mitigate risks but still has much to do to use clinical information to rate risk accurately and to develop action plans.

- Positive Practices and Improvements Made
    - The statewide risk assessment policy, with guidelines for rating risk, was in use at the Facility. The Facility had created supplementary tools that IDTs could use in the risk assessment planning process.
    - The Facility had a very active Physical and Nutritional Management Committee. This group met at least monthly and was chaired by the Facility Director.
- Improvements Needed
    - The risk assessment process in place at the Facility did not always accurately assess risk; however, the Monitoring Team noted improvement in the risk assessment process for physical nutritional management issues.
    - Few risk ratings adequately rated the individuals on all risk categories based on supporting clinical data. Integrated Risk Ratings varied in the quality of substantive clinical data to support the various risk ratings, over time and with the different IDTs. Risk categories were not consistently rated accurately according to the Risk Guidelines and/or the individuals' heath status based on medical history, treatment regimens, and other supporting clinical data that was noted.

- Not all staff needed to participate in a risk assessment discussion at the ISP meetings were in attendance at ISP annual planning meetings observed during the compliance visit.

Psychiatric Care and Services

The Facility continued to make progress in many areas. Positive practices noted were in the area of integrated care, as a result of the introduction of combined case formulations that clarified how learned behaviors and psychopathology each contributed to individuals' behavioral profiles. There were also improvements in the way that psychiatric data was reported, although the process by which psychiatrists and psychologists identified what should be tracked needed further attention. Progress in reducing unnecessary polypharmacy was impressive. However, Facility efforts to develop behavioral plans to minimize the need to use pre-treatment sedation remained at an early stage and continued attention to that area is needed. Also, attention is needed to the areas of justification of diagnoses, and to the development of the system for tracking and reporting psychiatric data.

- Positive Practices and Improvements Made
  - All psychiatrists were board certified in psychiatry and all had sufficient experience with intellectual disabilities. The psychiatrists actively and appropriately participated in the interdisciplinary process.
  - Procedures were in place to conduct evaluations and diagnoses prior to the administration of psychotropic medications.
  - The process of coordination of care between psychiatry and neurology for individuals prescribed medications for both seizures and mental health disorders was strong.

- Improvements Needed
  - The process for developing plans to minimize the need for medical restraints remained at an early stage.
  - Improvement was noted in the way psychiatric diagnoses were substantiated and target symptoms for treatment were identified, but further improvement in these areas was needed.
  - Reiss screens had been administered across the campus, but the Facility had not completed needed evaluations for individuals identified by the screens.
  - Combined assessment and case formulations are being put in place, but most individuals do not yet have them. In some cases, ISPs did not include psychiatric information that is important for the individual.
  - Facility wide monitoring of side effects was in place, but not all individuals who needed side effect screens had them.
  - Monitoring of medication treatments for treatment response needs further attention.

Psychological services

Throughout the current site visit, it was quite evident that the Facility had invested considerable effort into improving services. Substantial changes had been implemented in relation to several Provisions of Section K since the previous site visit. Some, but not all, of the changes had resulted in considerable progress.

- Positive Practices and Improvements Made
  - The Facility had made broad and creative changes made in the approach to counseling services and the tracking of counseling data. Although additional work was necessary in a small number of areas, the Facility had developed an evidence-based model for counseling services in six months, as well as implemented the new model for all individuals who were receiving counseling.
  - Substantial improvements had also been achieved in relation to PBSP data graphing and progress notes.
  - The continued focus on reducing unnecessary polypharmacy has resulted in a gradual and sustained decrease in polypharmacy.
  -
- Improvements Needed
  - Considerable effort had been made in integrating behavioral and psychiatric assessments and treatments. This produced a document framework within which both disciplines could present assessment findings and combine intervention strategies. In many circumstances, however, the information regarding mental illness did not reflect the evidence-based process necessary to integrate with the behavioral model for assessment and treatment.
  - The Facility was not making effective use of data in developing treatment decisions.
  - There was a lack of reliability measures for treatment data. There was limited assessment of treatment integrity.
  - There remained a pervasive lack of intellectual and adaptive behavior assessments.

<u>Medical Care</u>

It was most obvious during this review that many of the new procedures, and practice standards are starting to be implemented. Despite non-compliance, Medical Services is clearly heading in the right direction, and the quality of medical care has significantly improved. It should be noted that the Facility had significant turnover of clinicians during the past six-month period, resulted in delays in fully implementing new procedures.

- Positive Practices and Improvements Made
  - There was significant improvement of medical assessments by the clinician, and improved Integrated Progress Notes (IPNs) that are more comprehensive and include an assessment and plan.
  - Clinicians are more engaged in general health care issues of the individual.
  - There has been noticeable improvement with following up by the clinician on the initial assessment of acute medical conditions.

- The Facility had taken the initial steps to develop a meaningful medical QA process that included identifying initial core indicators, and for developing a database solution that will be used to analyze data elements.
- The Facility had taken steps to develop a solution to manage clinical data elements. Throughout its review, data was efficiently and accurately provided because of improvements made by the Facility's information technology department.

- Improvements Needed
  - There remains a need for clinicians to follow up on acute medical conditions to full resolution, and ensure that all clinical efforts are well documented.
  - All clinical conditions must have a comprehensive medical plan in place to address each condition identified.
  - The Facility needs to improve its approach to neuromotor and musculoskeletal conditions, such as cerebral palsy, spasticity, contractures, degenerative spine disease, and arthritis.
  - The development, and implementation of specific audit tools, for common and serious conditions, was a positive finding by the Monitoring Team; however, continued improvement and development of these assessments is required.
  - The Facility did not have effective policies and procedures that help ensure that standard of care practice is followed, and the Facility's policy for medical services is not consistently adhered to by the clinical staff.

<u>Nursing Care</u>

The Nursing Department continued to demonstrate a high degree of enthusiasm and commitment to moving toward compliance with all provisions of the Settlement Agreement. There had been significant improvement in many areas, although no provision was yet in substantial compliance. Improvements are still needed in the quality of nursing assessments and care plans.

- Positive Practices and Improvements Made
  - The Diabetic Educator Nurse had completed a study to evaluate the effectiveness of the Diabetic Education Services and intervention on improving individuals' diagnosed with diabetes glycemic control. The study found evidence of improved glycemic control. She had formed a Diabetic Support Group, comprised of interdisciplinary staff, individuals' diagnosed with diabetes and those who were at risk for developing diabetes, and family representatives to promote increases social activities, interactions, and healthy food choices.
  - The Wound Care Nurse worked collaboratively with the Individual Support Teams had continued to reduce/prevent the incidences of skin integrity issues. At the time of the review only four individuals had skin breakdown that was being aggressively managed. This was commendable considering the Facility's census of 504, of which many individuals were identified to be medically complex and/or fragile.

- The Infection Control Preventionist had made significant improvements in the organizational structure and quality of the Infection Control Program.
- The Facility's Emergency Response System continued to make significant improvements.
- The Nurse Educators had trained 100% of the non-nursing staff responsible for providing direct care to individuals on the Clinical Indicators of Health Status Change Class at New Employee Orientation and were also providing training to incumbent staff.
- The Medication Variance Policy was implemented and data was being gathered for each type of medication variance. The Medication Variance Committee was in the process of analyzing data and determining how to represent it, and make it useful to improve medication.

- Improvements Needed
  - Although 18 nursing protocols had been implemented since the last compliance review, there remained opportunities for continued improvement for all aspects of managing and documenting care according to the established protocols.
  - Although the Nursing Care Monitoring Tools continued to be completed, and data analyzed and trended, few systemic Corrective Actions Plans had been developed and implemented.
  - Although continued efforts 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 process of developing Integrated Risk Assessment involved the nurses gathering information, aggregating it, and developing draft assessments; this was still an evolving process, and there was continuing need for the other relevant disciplines to complete their respective areas timely.
  - Nursing staff administering medications needs enhanced dysphagia training.
  - The nursing staff administering medications enterally should also strictly adhere to stoma assessments and care practices.

<u>Pharmacy Services and Safe Medication Practices</u>
The Monitoring Team would like to compliment the Facility, and the Director of Pharmacy for the exceptional level of dedication in working towards compliance for Provision N. Following review of this report, the reader should appreciate that only minor enhancements are needed in the areas determined not in compliance, to become compliant.

- Positive Practices and Improvements Made
  - Review of new medication orders, follow-up documentation by the pharmacist, and the newly revised procedure for medication dispensing indicated that the pharmacy is appropriately assessing new medication orders, indicated

that they have reviewed each script for appropriateness, need for laboratory assessments, and side effects, and that when necessary, physicians appropriately address pharmacists' recommendations.
    - Clinical Pharmacists had significantly improved the overall quality and timeliness of the QDRR process.
    - Appropriate data elements addressing clinical issues related to the use of sedating benzodiazepines, polypharmacy, and STAT medication use are being collected, analyzed and reported to committees, and acted upon.
    - There is a high quality of Adverse Drug Reaction (ADR) monitoring, tracking, analyzing and reporting.
    - The Pharmacy Department maintains a robust Drug Utilization Evaluation (DUE) process that is supported by policy.

- Improvements Needed
    - QDRRs must rely on clinical data, such as laboratory studies, body weight, vitals, and abdominal girth, from the same quarter in which the QDRR is being performed, must include a comprehensive assessment for metabolic syndrome, and must document pharmacist assessment of pharmacotherapy effectiveness and possible side effects.
    - The Facility does not collect important data to ensure metabolic syndrome is assertively monitored and managed, including periodic glucose monitoring and measurement of abdominal girth.
    - Physicians need to document an action plan for pharmacy recommendations.
    - Despite meaningful participation by nursing and pharmacy staff, physician services did not participate at the medication variance committee meetings, did not assertively address medication variances through its own physician provider committee, nor did it provide the medication variance committee with suggestions on how to remedy prescriber variances.

<u>Physical and Nutritional Management</u>

Overall, there has been a positive movement on the areas of Section O in which the focus lies on the presence of a committee or the development of a policy or process, The primary concerns that remain focuses more of observing all of these policies being implemented at the level of care. This remains an area that was pervasively lacking.

- Positive Practices and Improvements Made
    - DSSLC had taken steps forward with regards to the PNMC and PNMT. It was evident that both of these groups provided a much-needed service to the area of PNM. 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 IDT as well.
    - The Facility developed a formal monitoring process that is based upon level of risk.
    - There was improved participation by the IDT in response to hospitalizations.
    - A Speech Language Pathologist (SLP) assignment was dedicated to PNM.
    - There was a significant increase in the number of individuals who had been assessed by the PNMT or IDT.

- Improvements Needed
    - Standard assessments continued to lack the comprehensiveness needed to mitigate the risk associated with PNM. Many times, the assessments were only comprehensive when conducted by the PNM and in response to an illness. It is essential that routine assessments do a better job in identifying root causes of incidents and the development of proactive plans of care.
    - PNMPs were not clearly developed with input from all members of the IDT or reviewed consistently by the IDT.
    - 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 IDTs 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. 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.
    - 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 was not knowledgeable of the plans and why the proposed strategies were relevant to the individuals' well being.
    - There was no process in place to ensure PNM supports for individuals who are determined to be at an increased level of risk were only provided by staff who have received the competency based training specific to the individual.
    - Pathways to oral intake (PO) status and the implementation of oral motor strategies to improve oral control and maintenance were not implemented or identified consistently.

<u>Physical and Occupational Therapy</u>

The policy component of Section P showed improvement but DSSLC continued to lack in the areas that focused on assessment and/or the implementation of strategies intended to mitigate risk and/or enhance skills.

- Positive Practices and Improvements Made
    - The Facility provided an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.
    - 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.
    - Based on reviews of PNMPs for 27 individuals (sample #1, #2, and #3), equipment was specified for 27 of 27 (100%) plans reviewed.

- DSSLC had installed various bathing options and were in the process of ordering more options for individuals. (shower chairs, trolleys and submersible tubs) in an effort to expand options for individuals who require more intensive interventions during this activity.

- Improvements Needed
  - 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.
  - 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.
  - Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. Restorative programs were not readily utilized to minimize regression of skills.
  - Therapy services were not consistently integrated into the PSP.
  - Therapy 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. This includes pulled and relief staff.

<u>Dental Services</u>

Due to staffing transition, process improvements were delayed but appear to be in process. Since the last review period, the dental department has maintained a robust process to address dental emergencies, incorporated new technology, such as portable x-ray devices, enhanced the reviews of individuals during their annual dental assessments, and is in the process of implementing a dental database system. The Monitoring Team compliments the Facility for moving forward, despite the noted changes with staff.

- Positive Practices and Improvements Made
  - The Facility maintained an effective mechanism that ensured the delivery of emergency dental services.
  - The Facility has incorporated new technology, such as portable x-ray devices.

- Improvements Needed
    - There were significant issues with regards to outcomes of oral health care and oral hygiene efforts, including the use of suction toothbrushing, that was provided at the living area, as there was a very high incidence of poor oral hygiene, plaque, gum bleeding, and calculus formation.
    - There was not an effective QA process to assess positive and adverse outcomes of dental services.
    - There is a need for an effective method to manage dental related to scheduling, missed appointments, and type of services provided and required. This is in process of being addressed. The Facility is in the process of implementing a dental database system.
    - The Facility did not have a robust process that ensures that dental services are adequately reflected in the personal support team/interdisciplinary team process.

Communication

DSSLC has increased staffing, but this was just recently achieved. There had been minimal progress in providing comprehensive assessments of communicative functioning, implementation of programs, and use of alternative and augmentative equipment (AAC).

- Positive Practices and Improvements Made
    - Staffing was increased from 3.5 FTE to 7.5 FTE.
    - DSSLC developed a monitoring system that should assist in determining functionality of goals as well as staff's knowledge regarding the implementation of goals.

- Improvements Needed
    - 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.
    - AAC devices were not consistently portable, functional or available in a variety of settings. DCPs interviewed were not knowledgeable of the communication programs.

Habilitation, Training, Education, and Skill Acquisition Programs

No provisions of this section were in substantial compliance. There were instances where the Facility had demonstrated both creativity and improvement. DSSLC had recently opened a retail site downtown that could provide opportunities for both vocational activity and community involvement. The Facility maintained a high level of community outings. However, skill acquisition program goals were not guided by assessments and did not include all elements needed.

- Positive Practices and Improvements Made
    - The Facility had opened Impressions, a retail outlet where crafts and artwork created by individuals living at the Facility would be sold to the general public. In addition, plans called for Impressions to be used as a training site where individuals would create items to be sold as well as practice skills beneficial for transitioning to community living, such as retail sales skills, socialization, and money management.
    - There were relatively high levels of community outings.

- Improvements Needed
    - In many of the residences at the Facility, individuals were offered minimal supports or opportunities for learning.
    - Skill acquisition programs, although provided a new format, lacked many of the elements essential to learning.
    - Assessments of individual needs, strengths, and preferences were often not conducted, and those assessments that were conducted frequently were not used in the development of skill acquisition programs.

<u>Most Integrated Setting</u>

The number of individuals moving to community living remained relatively low, although there were numerous referrals. There was some progress noted in certain CLDP processes, but deficits in the Facility's assessment processes continued to hamper these efforts to develop and implement adequate transition planning. Post Move Monitoring (PMM) was implemented generally in a sufficiently rigorous manner for individuals who had moved from DSSLC, but there were significant concerns related to PMM being provided for other SSLCs.

- Positive Practices and Improvements Made
    - The Facility reviewed the CLDP with the individual and LAR to facilitate their decision-making regarding supports and services needed for community living.
    - PMM Checklists generally appeared to be completed in a timely manner and that the Post-Move Monitor generally continued to implement the PMM process in a sufficiently rigorous manner for individuals who moved from DSSLC.

- Improvements Needed
    - DSSLC still failed to adequately assess, plan for, and implement a plan for each person's needs for education and awareness about community living options. The Monitoring Team encourages the Facility to continue to work toward development of an individualized education/awareness strategy for each individual that takes in to account his or her specific learning needs.
    - Continuing deficits in assessments also translated to many instances in which the IDT failed to identify in each individual's ISP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, or the

major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences and the strategies intended to overcome such obstacles.
  - There were gaps and deficits in Post Move Monitoring for individuals who had moved from other SSLCs; these could have resulted in serious consequences.

Consent

This Section was not yet in compliance, but the Monitoring Team commends the Facility for considerable progress made over the past six months in policy development and staff training.

- Positive Practices and Improvements Made
  - DADS State Office had issued a new policy, DADS Policy 019: Guardianship, effective 3/7/2012, with five Exhibits, that provided some guidance to the Facility in the development and maintenance of 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. The Facility had localized this policy.
  - The Facility maintained 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, using criteria that were tied to its Integrated Risk Rating data. This was a creative approach to attempting to obtain objective and individualized information on which to base these decisions.
  - DSSLC had also very recently begun to pilot a new expanded Rights Assessment. The Human Rights Officers (HROs) had provided training on the use of this new tool to QDDPs in a pilot area and had worked with IDTs in these areas to complete six of the new Rights Assessment as of the time of the compliance visit. There was evidence that the Rights Assessments completed with the assistance of the HROs contained a more thoughtful and thorough approach to assessing an individual's needs in the area of decision-making and addressing them in ISP Action Plans.
  - The Facility has made significant efforts toward developing a variety of supports for individuals who require some level of assistance in making decisions, such that guardianship is not the only option.

- Improvements Needed
  - The DADS policy provided little guidance as to how IDTs should assess an individual's decisional capacities, and the Facility did not have a methodology in place to determine the actual need for guardianship.
  - Although the Facility had established a Guardianship Committee that been meeting regularly since September 2011, and its responsibilities had been spelled out, it was not yet clear the members had a full understanding of what actions they were expected to take.

Recordkeeping and General Plan Implementation

The Facility continued to make progress on all provisions of this section. The Facility maintained a unified record as well as a shared drive that can make useful information (such as assessments) accessible to the IDT.

- Positive Practices and Improvements Made
  - There had been continuing development and implementation of policies to address the requirements of the Settlement Agreement.
  - There is a robust records audit system in place. Random selections of records to be audited was implemented. Interrater reliability checks are done regularly and are independent.
  - Follow-up on items identified in records audits as needing correction (whether corrections to the documents or corrective actions to minimize errors, such as retraining) have been completed consistently, and the Facility has an excellent process to ensure reported corrections were actually implemented.
  - Clinical staff report use of information in the record for making decisions. Availability of the record and use of information from the record at IDT meetings was evident
- Improvements Needed
  - Continuing efforts must be made to ensure policies are implemented accurately.
  - Although some systemic actions have been taken to address documentation issues, there has not been review of the effectiveness of these actions except for review of the monitoring tools.
  - The Facility did not have a process to determine whether information in the record was used effectively to identify progress or decline in health and behavioral status of individuals for purposes of making treatment decisions, and the Monitoring Team found information missing but not commented on in reviews.
  - There was evidence of lack of use of the record based on lack of implementation of programs.

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 Self-Assessment 3/16/12 2. DSSLC Action Plan 3/8/12 3. DADS Policy 001: Use of Restraint, 8/31/09 4. Settlement Agreement (SA) Section C Presentation Book (undated) 5. DSSLC Policy CMGMT-20 Limitation of Restraint as a Crisis Intervention 9/7/11 6. DSSLC Policy CMGMT-21 Dental/Medical Sedation and Restraint 8/5/11 7. DSSLC Policy CMGMT-24 Dental Services Procedure: Desensitization 12/15/11 8. PMAB Training Curriculum (undated) 9. Training Curriculum for RES0105 (Restraint: Prevention and Rules for Use at MR Facilities) and RES0110 (Applying Restraint Devices) undated 10. Nursing Responsibilities Related to Restraints – Guidelines 2/16/12 11. Section C Monitoring Report 2/12 12. Sample of staff training records (Sample C.2) 13. Restraint log for crisis intervention restraints 9/2/11 to 2/27/12 14. Restraint log for medical restraints 9/2/11 to 2/27/12 15. Restraint log for dental IV sedation 9/2/11 to 2/27/11 16. Restraint log for protective mechanical restraints 9/2/11 to 2/27/12 17. 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 Individual Support Plan Addendums (ISPAs) for five restraints of Individuals #110, #240, and #537 18. Restraint documentation files for sample (Sample C.3) of pretreatment sedation medical restraint for three medical procedures: Individuals #398 (2-10-12, CT spine), #210 (10-13-11, Doppler study), and #360 (2-3-12, Mammogram) 19. Restraint documentation files for sample (Sample C.4) of pretreatment sedation medical restraint for three dental procedures for Individuals #222 (12/18/11), #332 (11-29-11), and #311 (11-06-11) 20. Restraint documentation files for sample (Sample C.4) of three instances of Total Intravenous Anesthesia (TIVA) sedation: Individuals #209 (1-12-12), #731 (12-14-11), and #772 (2-13-12) 21. Documentation for individuals who were restrained more than three times in a rolling 30-day period for Individuals #336, #337, and # 381 22. List of Restraint Monitors 2/27/12 23. DSSLC Restraint Monitoring training material 2/10/12 24. List of individuals injured during restraint 9/2/11 to 4/2/12 25. List of individuals with a Safety Plan for Crisis Intervention (SPCI) 4/2/12 26. List of individuals with a desensitization plan and sample plans

	27. Restraint Trend Analysis 2/12 28. Restraint Reduction Committee minutes 10/3/11, 11/3/11, 12/5/11, 1/6/12, 2/3/12, and 3/6/12 29. DADS Report MHMR0102 Percent of All Employees Completing Courses of Training Program 3/1/12 **People Interviewed:** 1. Jill Wooten, BCBA, Section C Lead 2. Karen Bishop, Psychology Assistant 3. Delia Schilder RN, Chief Nurse Executive 4. Sibylle Graviett, RN-Case Manager Supervisor 5. Sherri Courtney, RN, Nursing Operations Officer 6. Ken Horstman, Director of Residential Services **Meetings Attended/Observations:** 1. Incident Management Team (IMRT) 4/2/12 2. Restraint Reduction Committee 4/4/12 3. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 4/3/12 4. Timberhill Unit morning meeting 4/5/12
	Facility Self-Assessment: The DSSLC's self-assessment reported that Provisions C.2 and C.8 were in substantial compliance with the Settlement Agreement (SA). The Monitoring Team did not find sufficient evidence to determine substantial compliance with Provision C.2. This was attributable to conflicting information recorded on Face-to-Face Assessment/Debriefing documents from that recorded on Restraint Checklists. The DSSLC self-assessment reported it had not yet achieved compliance with the other provisions of Section C of the SA and the Monitoring Team concurs. The Facility's self-assessment process was thorough and detailed. It included policy review, data from its SA monitoring tools, and data developed and analyzed by the Behavioral Services Department. The Facility's Action Plan that accompanies the self-assessment included steps to improve processes that would lead to compliance with the Settlement Agreement. Additional action steps will need to be developed to address issues identified by the Monitoring Team which are not sufficiently addressed in the current Facility Action Plan.
	Summary of Monitor's Assessment: The primary obstacle to achieving compliance with Section C of the SA remains deficient practices and documentation associated with medical restraint. This observation was made in each of the last two reviews. Some progress has been made but much more is needed. Policies, procedure, and documentation systems for restraint use were in place and for the most part require only minor revisions and continued vigilance through the Facility's monitoring process to achieve compliance. Provision C.8 was in substantial compliance with the Settlement Agreement. Contrary to the Facility's self-assessment, the Monitoring Team did not find sufficient evidence to determine substantial compliance with

	Provision C.2. DSSLC's policies that govern restraint appear sufficient, if consistently applied, to achieve compliance with the SA. With the exception of three individuals who had Safety Plans for Crisis Intervention and had special circumstances associated with their treatment plans (see Provision C.7) the frequency of use of crisis intervention restraint (not including restraint that is part of a Safety Plan for Crisis Intervention) had steadily decreased. The Facility averaged nine crisis intervention restraints per month in FY10, six per month in FY11, and five per month in FY 12 through February, 2012. The decrease in crisis intervention restraint 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. Additionally, the Facility is to be commended for its practices that had resulted in the continued decrease in the frequency of use of crisis intervention restraint. No individuals were the subject of emergency chemical restraint since the last review. The use of medical restraint involving pre-treatment sedation had decreased. The February Trend Analysis reported a monthly average of 40 oral pretreatment restraints in the five-month period April through August, 2011. The monthly average for the most recent five months was 32. This was a 20% decrease. The use of medical restraint involving TIVA had steadily increased since the last review, from 15 in October to 35 in February. Facility staff reported this was primarily the result of resources being made available for TIVA. During this most recent five month period TIVA was used an average of 27 times a month. In the prior five month period TIVA was used an average of 17 times a month. This was a 60% increase. All required staff training (for staff in general, and specifically for staff acting as Restraint Monitors) had been completed. The Facility's restraint review practices were thorough, comprehensive, and effective in identifying factors which needed to be addressed to minimize the need for future use of restraint with the particular individual subject to review. The unit meeting observed by the Monitoring Team, led by the unit's Behavior Analyst, was exemplary. The discussion was interdisciplinary, included data review, and through the interdisciplinary discussion led to suggested changes in the Individual's Positive Behavior Support Plan (PBSP) and Individual Support Plan (ISP). Restraint procedures used across the Facility were reviewed at monthly meetings of the Restraint Reduction and Behavior Support Committees. The meetings observed by the Monitoring Team confirmed that meetings were substantive in nature and included both policy and procedural discussions. It was evident these committees engage in substantive review, problem solving, and the development of specific

	recommendations. A significant area of noncompliance was the requirement that if medical restraints are used for routine medical or dental care for an individual, the ISP for that individual must include treatments or strategies to minimize or eliminate the need for restraint. The Facility was able to provide plans that addressed this requirement for only two individuals. The Facility reported the staff person hired to concentrate on this aspect of the ISP had left and the position had just recently been re-filled. The Facility noted that the Monitoring Team should expect to see significant progress in this area at the next review. The sections of the Annual Physician Summary intended to document restrictions or limitations on the use of restraint were overly general. For example, one individual's active problem list included several medical conditions that should have been considered in assessing the safety of use of restraint. The physician indicated "based on my knowledge of this individual there are no known health risk to the use of restraint." The Monitoring Team believes the listed active problems did potentially present a health risk in the use of restraint. There was no indication the medical issues on the active problem list were specifically considered. The need for improved work processes associated with medical restraint noted in the last report remains problematic. Many records reviewed did not include documentation required by policy. The Facility's monitoring process needed to be more rigorous. Compliance rates presented with respect to medical restraints were much higher than that noted by the Monitoring Team. Because of the low level of compliance in key provisions of medical restraint policy implementation it is likely the Facility's monitoring data is not accurate. Facility policy prohibits prone restraint and this prohibition is reinforced through staff training. However, the Facility, through its post restraint review processes, identified one instance of use of prone restraint. The individual restrained was not injured. The restraint was reported as an allegation of physical abuse (both employees were immediately placed in no direct contact status) and both employees, after the investigation was completed, were discharged. The Monitoring Team review of restraint records, restraint reduction committee minutes, and minutes of the Incident Management Review Team (IMRT), did not discover any additional use of prone restraint. The Facility is to be commended for maintaining a restraint review process that identified the use of this prohibited restraint, and for taking immediate action in investigating the situation and following up with employee administrative action. Finally, the Facility is to be commended for maintaining a self-assessment process that identifies errors in documentation and restraint practice and uses these data to determine training needs.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone	Facility Self-Assessment: The Facility engaged in the following activities in conducting its self-assessment of this	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Provision: The self-assessment process included a review of current policies (Dental/Medical Sedation and Restraint Policy CMGMT-21 and DSSLC Limitation of Restraint as a Crisis Intervention Policy CMGMT-20) to determine if policy addressed all requirements of the SA; a review of monthly restraint audit compliance results for the months of October 2011 through January 2012; a review of the facility Restraint Trends analysis reports for the months of October 2011 through January 2012; and, a review of the facility Quarterly Quality Assurance/Quality Improvement (QA/QI) restraint audit compliance results for September 2011 through November 2011 quarter and November 2011 through January 2012 quarter. The Facility's self-assessment reported the following: The review of the current policies related to use of restraint (CMGMT-21 and CMGMT-20) found the policies to be directed towards compliance with the settlement agreement. The monthly restraint audit results for December 2011and January 2012 indicated regression in restrictions governing the use of restraint such as restraint being implemented only after a graduated range of less restrictive measures were exhausted or considered in a clinically justifiable manner. Lower compliance scores appeared to be related to documentation issues on restraint checklists each month (different individuals and restraint checklists). There were no individuals chemically restrained in response to a behavioral crisis since 9/23/11. There was one individual placed in a prone position during a behavioral crisis restraint since 9/23/11. Video surveillance monitoring staff identified the use of this restricted type of restraint and informed the facility investigators. This notification occurred just as the Restraint Monitor finished the restraint de-briefing. The staff members involved were immediately removed from individual contact pending investigation. Results of the investigation ultimately resulted in the termination of the involved staff. Consistently high compliance scores for elements of Provision C.1 were noted for the months of September, October, and November of 2011. Compliance scores of 90% or higher were noted with the exception of the element of obtaining a physician's order and documentation of information by staff at shift change. Low compliance scores	

#	Provision	Assessment of Status	Compliance
		were noted on these two elements in the month of October 2011. On the spot training was conducted with staff making these errors. Compliance results for these two problem areas were noted to be 100% of sampled restraints in the November 2011 restraint audit. Compliance scores for the restraint audits for the quarter of November and December 2011 and January 2012 indicated errors in shift change documentation, for a different individual's restraint than that noted in the previous quarter, which required on-the-spot training for staff making errors. In addition, there were problems noted with doctor's orders for two medical/dental restraints (different from those identified in the previous quarter) in the January 2012 audit. Although both restraints had doctor's orders there were errors in the orders such as a lack of a doctor signature, noted by the restraint auditor. Based on the findings from its self-assessment, the Facility determined this provision was not in substantial compliance because compliance results from monthly restraint audits did not consistently indicate high levels of compliance in all elements within the C. 1. Provision, indicating a need for improvement. In addition, although progress was being made related to dental/medical sedation documentation there continues to be a need for improvement in this area. <u>Monitoring Team Findings</u> <u>The Facility is to be commended for maintaining a self-assessment process that identifies errors in documentation and restraint practice and uses these data to determine training needs.</u> 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. The area of greatest concern was the use of medical restraint and attendant nursing responsibilities. To address this, the Facility had created a six-page set of guidelines related to nursing responsibilities. This was issued on 2/16/12 and all nurses had been subsequently trained in these procedural requirements. As described in Provision C.4 implementation of these procedural requirements was variable. 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, in part, its self-assessment rating.	

#	Provision	Assessment of Status	Compliance
		The DSSLC had three individuals (Individuals #336, #337, and #381) who were frequently restrained, each of whom had Safety Plans for Crisis Intervention and special circumstances associated with their treatment plans. Discussion of this is presented in Provision C.7. For other individuals living at the DSSLC, the frequency of use of crisis intervention restraint (not including restraint that is part of a Safety Plan for Crisis Intervention – SPCI) had steadily decreased. The Facility averaged nine crisis intervention restraints per month in FY10, six per month in FY11, and five per month in FY 12 through February, 2012. The use of medical restraint (pre-treatment sedation) had decreased. The February Trend Analysis reported a monthly average of 40 oral pretreatment restraints in the five-month period April through August, 2011. The monthly average for the most recent five months was 32. This was a 20% decrease. The use of medical restraint (Total Intravenous Anesthesia - TIVA) had steadily increased since the last review, from 15 in October to 35 in February. Facility staff reported this was primarily the result of resources being made available for TIVA. During this most recent five month period TIVA was used an average of 27 times a month. In the prior five month period TIVA was used an average of 17 times a month. This was a 60% increase. The decrease in crisis intervention restraint 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. Additional information on this is included in Sections J and K of this report. The Facility is to be commended for its practices that had resulted in the continued decrease in the frequency of use of crisis intervention restraint. 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 three individuals and five restraint episodes, representing 20% of physical restraint episodes since the last review. One of the individuals in the sample (representing two of the five restraints in the sample) had a Safety Plans for Crisis Intervention (SPCI). The others did not. A separate sample was selected for medical restraints. The Facility prepared a documentation file to include the Restraint Checklist, Face-to-	

#	Provision	Assessment of Status	Compliance
		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 presented 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. The circumstances associated with these three Individuals are presented in Provision C.7. <u>Prone Restraint</u> Facility policy prohibits prone restraint and this prohibition is reinforced through staff training. The Facility, through its post restraint review processes, identified one instance of use of prone restraint. The Individual restrained was not injured. The restraint was reported as an allegation of physical abuse (both employees were immediately placed in no direct contact status) and both employees, after the investigation was completed, were discharged. The Monitoring Team review of restraint records, restraint reduction committee minutes, and minutes of the Incident Management Review Team (IMRT), did not discover any additional use of prone restraint. <u>Other Restraint Requirements</u> 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 had noticeably improved since the last review. This is likely attributable to the Facility's restraint review process and its ability to quickly detect documentation issues, correct them, and retrain staff as appropriate. The Facility Section C Monitoring Report presented data from January, 2011 through February, 2012. This report showed a compliance rate for Provision C.1 averaging 79% since the last review by the Monitoring Team. The compliance rate for February, 2012 was 76%.	

#	Provision	Assessment of Status	Compliance
		The following are the results of the review by the Monitoring Team for the restraint sample: In five of five records in the sample (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. In five of five records in the sample (100%), 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. Other than determining if the correct box was checked on an FFAD (or drawing conclusions from certain data on a Restraint Checklist) it is difficult 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 were 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. These continued improvements, along with the data presented earlier, lead the Monitoring Team to believe it is likely that restraint is used in a clinically justifiable manner and not for the convenience of staff. Additionally, the Monitoring Tools used by the DSSLC to measure compliance with this part of the Settlement Agreement (SA) showed consistently high compliance with this specific requirement. In five of five restraint records (100%), 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. No individuals were the subject of emergency chemical restraint since the last review. Facility policies identify a list of approved restraints. All restraints reviewed by the Monitoring Team were policy-approved restraints. The Monitoring Team sample of crisis intervention restraints found a high degree of compliance with this provision. The Facility's monitoring and post restraint review processes identified areas of non-compliance. The Monitoring Team identified substantive compliance issues with the use of medical restraint. These are described	

#	Provision	Assessment of Status	Compliance
		in Provision C.4 and impact compliance with Provision C.1.The Facility self-assessment also identified this problem. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	Facility Self-Assessment: The Facility engaged in the following activities in conducting its self-assessment of this Provision: The self-assessment process included a review of monthly restraint audit compliance results for the months of October 2011 through January 2012 and a review of Quarterly Quality Assurance/Quality Improvement (QA/QI) restraint audit compliance results for September 2011 through November 2011 quarter, and November 2011through January 2012 quarter. The Facility's self-assessment reported the following: Data reviewed from the September, October, and November 2011 quarter of restraint audit compliance results indicated compliance ratings of 98% for Provision C.2. Data reviewed from the November and December 2011 and January 2012 quarter of restraint audit compliance results, indicated quarterly compliance ratings of 92% for Provision C.2. One restraint audit, for one individual, in the January 2012 audit sample, indicated that at the time of the audit the restraint auditor could not easily find the restraint checklist associated with this medical restraint and marked this element as "no". This was the only noted problem in the sampled restraint audits completed for the past six months. Based on the findings from this self-assessment, the DSSLC determined this provision was in substantial compliance because there is evidence that restraints are consistently terminated as soon as the individual is no longer a danger to him/herself or others. Monitoring Team Findings: Three (60%) 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. The	Noncompliance

#	Provision	Assessment of Status	Compliance
		Restraint Checklist for Individual #110 (restraints on 1/15/12 and 1/13/12) recorded the release code M – "released due to not able to maintain restraint correctly." The circumstances surrounding these restraints, explained in interview, indicated the restraint and release were handled appropriately; however, nothing recorded on the Restraint Checklist, FFAD, or Behavior Services Staff Debriefing provided any explanation of these circumstances. In fact, in both cases, the FFAD in section 2.6 recorded a "yes" to the query "restraint stopped when person restrained no longer a danger to self or others?" A more appropriate response would have been "no" with comments provided on the FFAD form. The Facility Section C Monitoring Report presented data from January, 2011 through February, 2012. This report showed a compliance rate for Provision C.2 averaging 93% since the last review by the Monitoring Team. The compliance rate for February, 2012 was 88%. The Monitoring Team does not concur with the Facility's self-assessment of substantial compliance with this provision of the SA because 40% of the restraints in the sample did not adequately describe the circumstances under which the restraint stopped, although Facility monitoring data reported only 93% compliance over the last five months.	
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	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision: The self-assessment process included a review of monthly restraint audit compliance results from October, 2011 through January 2012; a review of the facility Quarterly Quality Assurance/Quality Improvement (QA/QI) restraint audit compliance results for September 2011 through November 2011 quarter, and November 2011 through January 2012 quarter; a review of the facility training report for PMAB 0320 for prevention and management of aggressive behavior and use of restraint which would meet the criteria listed in Provision C.3; and, a review of the Restraint Trends Analysis report for the months of October 2011 through January 2012. The Facility's self-assessment reported the following: Data reviewed from the September, October, and November 2011 quarter of restraint audit compliance results indicated compliance ratings of 100% for Provision C.3. Data reviewed from the November	Noncompliance

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	redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	and December 2011 and January 2012 quarter of restraint audit compliance results, indicate quarterly compliance ratings of 89% for Provision C.3. November 2011 and January 2012 compliance results for C.3 were 100% for both months. Just one sampled restraint in December 2011 had one staff person not current in PMAB 0320. This one occasion is the only occurrence of non-compliance in staff training for the past six months. The Facility training report for PMAB 0320 indicates that the Facility compliance with this training has been at 96% and higher compliance for the months of September 2011 through January 2012. For the months of November, December 2011 and January 2012 the compliance with PMAB 0320 has consistently been 98%. There was one individual placed in a prone position during a behavioral crisis restraint since 9/23/11. Video surveillance monitoring staff identified the use of this restricted type of restraint and informed the facility investigators. This notification occurred just as the Restraint Monitor finished the restraint debriefing. The staff members involved were immediately removed from individual contact pending investigation. Results of the investigation ultimately resulted in the termination of the involved staff. Based on the findings from this self-assessment the Facility determined this provision was not in substantial compliance because results from restraint audits indicate that current policies and procedures are not consistently being implemented. The training compliance results indicate compliance with the training requirements related to C.3. <u>Monitoring Team Findings:</u> The Facility's policies and implementation activity related to restraint are discussed, in part, in Section C.1. 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 did	

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		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 first name of a Direct Care Professional (DCP) from the top 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. 99% RES0105 Restraint: Prevention and Rules for Use at MR Facilities 2. 99% RES0110 Applying Restraint Devices 3. 98% PMA0320 – PMAB Basic 4. 98% PMA0400- PMAB Restraint 5. 98% PMA0700 –PMAB Prevention 6. 99% PBS0100 – Positive Behavior Support These compliance percentages were sufficient to demonstrate substantial compliance with the training component of this provision. The Monitoring Team's finding is consistent with the Facility self-assessment. The Facility Section C Monitoring Report presented data from January, 2011 through February, 2012. This report showed a compliance rate for Provision C.3 averaging 93% since the last review by the Monitoring Team. The compliance rate for February, 2012 was 100%. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA. The Facility was in substantial compliance with the staff training component of this Provision; however, the implementation issues described in Provision C.1, and reported through the Facility monitoring of restraint documentation, preclude a finding of substantial compliance with this Provision.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision:	Noncompliance

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	year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	The self-assessment process included a review of monthly restraint audit compliance results for the months of October 2011 through January 2012; a review of the facility Quarterly Quality Assurance/Quality Improvement (QA/QI) restraint audit compliance results for September 2011 through November 2011 quarter, and November 2011 through January 2012 quarter; a review of the current list of individuals in need of a desensitization plan which included listing of plans implemented for these individuals for completion status of desensitization plans; and, a review of information from the Facility Director indicating if any individuals living at the facility had restrictions or prohibitions for restraint. The Facility's self-assessment reported the following: Data reviewed from the September, October, and November 2011 quarter of restraint audit compliance results indicated compliance ratings of 99% for Provision C.4. Data reviewed from the November and December 2011 and January 2012 quarter of restraint audit compliance results indicated quarterly compliance ratings of 90% for Provision C.4. Slight regression is noted in December 2011 and January 2012. One note from the restraint auditor for this element in January was that the most current Individual Support Plan (ISP) for an individual was not present in the electronic/virtual folders in order for her to complete her audit. The QDDP received notification of need for updated ISP. Because this information wasn't immediately available the element asking if the "medical restraint was documented in the individuals ISP" was scored as "no". Review of the list of individuals needing desensitization for routine dental treatment indicated that few desensitization plans had been developed since the last monitoring visit. The staff position within the Behavior Services department designed to work specifically with desensitization was vacated in December 2011. The position was posted and an individual was hired to begin in the position on 3/1/12. This loss of an employee, who was to develop and implement desensitization plans for individuals, temporarily impeded further progress in this area. The review of information from the Facility Director of any individuals meeting the criteria of restrictions or prohibitions for restraint indicated that no Physician has indicated that an individual had a restriction or prohibition against use of restraint. At this time, no individual has been identified in medical orders as having a restriction or prohibition against the use of restraint. Based on the findings from this self-assessment, the Facility determined this provision was not in substantial compliance because the policy and procedure related to	

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		Medical/Dental Sedation and Restraint was not being implemented consistently with a high degree of accuracy. <u>Monitoring Team Findings:</u> 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 ISP for that individual must include treatments or strategies to minimize or eliminate the need for restraint. The Facility had approved a full time position in the Behavior Services department designated for desensitization assessment and programming. The full time position had been filled just prior to the last review but vacated during the interim. At the time of this review the position had just been filled. This position was designed to assist in the assessment and evaluation of individuals for desensitization training and also to help develop desensitization training. To reach compliance, the Facility must make significant progress in establishing treatments or strategies to minimize or eliminate the use of restraints for routine medical or dental services Based on a review of five crisis intervention restraint records (Sample C.1), in all five (100%) there was evidence documenting that restraint was used as a crisis intervention. The Monitoring Team reviewed the five crisis intervention restraint records to determine if any restraint techniques were used that were prohibited by the individual's medical orders or ISP. The Facility's method for determining whether restraint techniques were used that was prohibited by the individual's medical orders is twofold. If the Individual had an SPCI a specific form completed by the physician was required. This form is entitled "Provider's Review and Approval of Proposed Restraint." If an Individual did not have an SPCI this topic was to be addressed in the document entitled "Annual Physician's Summary Physical Development and Health Evaluation." The Facility did not provide any information with respect to the additional SA requirement that the Interdisciplinary Team (IDT) also consider other variables (including variables that are non-medical in nature) that should be considered and documented in the Individual's ISP. Individual #537 from Sample C.1 had an SPCI and the appropriate physician review and approval form was provided. However, documentation by physicians did not indicate they had done thorough consideration of issues that could affect the use of restraint, types of restraint that would be acceptable or could not be used, or any special monitoring that would be needed to ensure safety. • The Annual Physician Summary for Individual #240 from Sample C.1 included the statement "based on my knowledge of this individual there are no known	

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		health risk to the use of restraint." In the Active Problem List in the Annual Physician Summary it was reported this Individual had a mediport implantation, a seizure disorder, and was overweight. The Monitoring Team believes the listed active problems do potentially present a health risk in the use of restraint. There was no indication these active medical issues were specifically considered by the physician when commenting on restraint use. The physician statement was overly general. • The Annual Physician Summary for Individual #110 from Sample C.1 included the statement "based on my knowledge of this individual there are no known health risk to the use of restraint." In the Active Problem List in the Annual Physician Summary it was reported this Individual had hypertension, obesity, COPD/asthma, a history of cardiac murmur, and an abnormal EKG. The Monitoring Team believes the listed active problems do potentially present a health risk in the use of restraint. There was no indication these active medical issues were specifically considered by the physician when commenting on restraint use. The physician statement was overly general. <u>Medical Restraints and Pre-Treatment Sedation</u> The Facility's approach to pre-treatment sedation was guided by (1) DADS Policy and Procedure 001 - Use of Restraints (08/15/09), (2) DSSLC Procedure- Desensitization (12/15/11), and (3) DSSLC Nursing Guidelines for Nursing Responsibilities Related to Restraints (updated 02/16/12). <u>Effort to Assure Safety during and after pretreatment sedation</u> The Monitoring Team met with Jill Wooten, Section C Lead, Sibylle Graviett RN, Case Manager Supervisor, Delia Schilder RN, CNE, and others from the Nursing Department to review how safety monitoring was provided during and after oral and/or IV pre-treatment sedation 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 at least every 30 minutes or more frequently if so ordered by the physician or dentist. Monitoring continued in the infirmary until scores of 8 or higher on the REACT measures for level of sedation were obtained. Care after release from the infirmary was guided by orders by the physician or dentist and more generally, the DSSLC Acute Care Nursing Plan for Post Anesthesia Care. That protocol called for vital signs and REACT scores every 15 minutes after release from the dental recovery area, for hourly vital signs for the first two hours after release from the infirmary, and then at least once per shift for 72 hours, <u>Medical monitoring of medical restraint (pre-treatment sedation)</u> To review monitoring for safety during medical restraints, the Monitoring Team sampled	

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		nine individuals who had received medical or dental pre-treatment sedation since the last review by the Monitoring Team. Individuals who had TIVA sedation, oral pre-treatment sedation for dental procedures, and oral pre-treatment sedation for medical procedures were sampled as follows: • Dental procedures with TIVA sedation: Individuals #209 (1-12-12), #731 (12-14-11), and #772 (2-13-12) • Dental procedures with oral pretreatment sedation: Individuals #222 (12/18/11), #332 (11-29-11), and #311 (11-06-11) • Medical procedures: Individuals #398 (2-10-12, CT spine), #210 (10-13-11, Doppler study), and #360 (2-3-12, Mammogram) Difficulties noted in the review included: • The Monitoring Team examined the records for evidence that vital sign monitoring was obtained during and after the procedure with the frequency outlined by the Facility protocols. Lapses were noted in each record. • The Monitoring Team examined the records for evidence that REACT scores were obtained as required. No evidence was provided for Individuals #332 and #210. In addition, for Individuals #209, #311, #506, and #731 the check list used to complete the REACT rating was either not dated/timed, or the information was not listed on the pre-post-sedation form • The Monitoring Team examined the records for evidence continued monitoring for 72 hours after the individual was released to his/her home, per the Facility protocol. No evidence was provided. • In the case of individual #360, no evidence for medical/nursing monitoring was provided. <u>Efforts to reduce the need for medical restraints during routine medical and dental procedures:</u> The Facility provided the Monitoring Team with a list of Medical/Dental Support Plans. As part of its quality assurance efforts, the Facility reported in its self-assessment that it had reviewed the list of individuals who required pre-treatment sedation for routine dental treatment, and concluded that few desensitization plans had been developed since the last review. In a meeting that took place on 4/2/12 with Jill Wooten BCBA and Section C Lead, the Monitoring Team was informed that the position for a psychology assistant, who would work with the Dental Department to reduce the need for restraints, had been vacated in December 2011. The position was filled in March 2012 by Ms. Karen Bishop. Ms. Bishop participated in the meetings led by Ms. Wooten, in which the need to continue to develop procedures to minimize the need for medical restraint were discussed.	

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		Since the last monitoring visit the Facility had developed a procedure on desensitization. That document clarifies that in general three attempts should be made to treat the individual without sedation, before pretreatment sedation is considered. If medical/dental sedation is required for the routine medical or dental care the individual is referred to the IDT to consider efforts to reduce the need for use of the sedation. The Monitoring Team was given a list titled "Desensitization List" which listed 153 individuals, whether they had a plan, and for those who had a plan, its type. Only one of the individuals sampled by the Monitoring Team had a plan in place. That was Individual #731. The plan called for the individual to walk to the administration building where the dental clinic is located and for the individual to stay for less than one minute in 20 of 24 data points by 1/2/13. The Monitoring Team was provided with a data sheet that showed three such data points in March 2012. In the pre-visit document request the Facility was only able to produce documentation of two examples of a desensitization plan having been developed and implemented. While onsite, the Monitoring Team afforded the Facility an opportunity to provide additional documentation, especially if it represented what the Facility thought was "good work". The Facility reported it had none to provide and indicated "it is our own expectation that we will have more desensitization plans to review during the next visit." Additionally, the requirement of the SA is that an Individual's ISP includes treatments or strategies to minimize or eliminate the need for medical restraint. The SA does not specifically reference the term "desensitization". There may be "treatments and strategies" different from, or in addition to, desensitization that the Individual's ISP should consider in this regard. <u>Overall status of efforts to minimize the need for pre-treatment sedation and the need to monitor for safety:</u> The Monitoring Team found that the development of plans to minimize the need for medical restraints were still at an early stage. The need for improved work processes associated with medical restraint, especially dental pre-treatment oral sedation, was noted in the last report and remains an area of concern and in need of improvement. The Facility Section C Monitoring Report presented data from January, 2011 through February, 2012. This report showed a compliance rate for Provision C.4 averaging 91% since the last review by the Monitoring Team. The compliance rate for February, 2012 was 82%. Because of the pervasive issues identified by the Monitoring Team associated with treatments and strategies to minimize or eliminate the need for medical restraint these compliance scores are likely overstated.	

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		The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision: The self-assessment process included a review of monthly restraint audit compliance results for the months of October 2011 through January 2012; a review of the facility Quarterly Quality Assurance/Quality Improvement (QA/QI) restraint audit compliance results for September 2011 through November 2011 quarter and November 2011 through January 2012 quarter; a review of training curricula for Restraint Monitors to assess appropriate content; a review of training records of current Restraint monitors to determine if all restraint monitors were current in their training; and, a review of a random sample of order forms for Medical/Dental Restraint/Sedation to determine if this form was used by all Providers in the sample. The Facility's self-assessment reported the following: There were no individuals subject to restraint away from the Facility. Restraint audit compliance results for C.5., for the past six months, indicated that face to face assessments are consistently conducted within 15 minutes of the start of restraint. Also, licensed healthcare professionals are consistently documenting vital signs and mental status of the individual while in restraint and the physician is specifying the type and schedule of monitoring to be conducted. A workgroup consisting of medical and nursing staff, residential services staff, and behavior services staff further clarified procedures related to the use of the Pre/Active/Post sedation checklist and the routing of this documentation throughout the entire monitoring process. Data reviewed from the September, October, and November 2011 quarter of restraint audit compliance results indicated compliance ratings of 94.8% for Provision C.5. One problem area noted in the October 2011 audits was related to a nurse incorrectly documenting vital signs and mental status of an individual in restraint. On-the-spot training was provided for this particular nurse to address errors. For the past six months compliance results related to nursing staff documentation had improved significantly. Data reviewed from the November and December 2011 and January 2012 quarter of restraint audit compliance results, indicated quarterly compliance ratings of 97.5% for Provision C.5. The training curricula for Restraint Monitors continued to be	Noncompliance

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		competency based. Restraint Monitors remained current in training and continued to receive training at least annually as required by the Limitation of Restraint as a Crisis Intervention policy and procedure. In a random review of the use of the Order form for Medical/Dental Restraint/Sedation it was noted that in three of five samples the physician/provider had used the correct order form. There were two physicians/providers who had not used the correct order form. Based on the findings from this self-assessment the Facility determined this provision was not in substantial compliance because procedures related to Medical/Dental Sedation/Restraint are not being consistently implemented. However, improvement in processes in this area had been noted in the self-assessment. <u>Monitoring Team Findings:</u> 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 34 names of staff authorized to perform the 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 34 staff designated as restraint monitors were selected for review. Three of the 10 were staff who served as the Restraint Monitor for the restraints noted in Sample C.1. 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; however, one staff was overdue for annual training in the three PMAB classes as well as the biannual	

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		training in CPR. Based on a review of five non-medical restraint records (Sample C.1), a face-to-face assessment was conducted in all five incidents of restraint (100%) by an adequately trained staff member. In five instances (100%), the documentation on the FFAD showed that an assessment was completed of the application of the restraint. In five instances (100%), the documentation on the FFAD showed that an assessment was completed of the circumstances of the restraint. The Monitoring Team observed continued implementation of a process the Facility started 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 FFAD). This was done by reviewing documentation and interviewing staff involved in the restraint episode. All five restraints in the sample included a "Behavior Services Staff – Debriefing Post Restraint" document. This document provided information on the application and circumstances of the restraint that was more detailed than information recorded on the FFAD. Four of the five (80%) documents did not indicate who did the review or the date of the review. None indicated whether or not the review received supervisory review. None of the five 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 circumstances associated with these three Individuals are discussed in section C.7 of this report. The Facility reported no instance of restraint occurring while an individual was away from the Facility. In the last report by the Monitoring Team it was noted the Facility did not have 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, the Facility reported it had implemented an Order Form for Medical/Dental Sedation/Restraint, effective 8/5/11. This form was not present in 65% of the records reviewed. Based on a review of five crisis intervention restraint records (Sample C.1), there was documentation that a licensed health care professional:	

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		• Conducted monitoring at least every 30 minutes from the initiation of the restraint in four (80%) of the instances of restraint. This did not occur for Individual #537. Physical restraint was applied on 1/17/12 at 10:16 p.m. The nurse was notified at 10:20 p.m. The nurse did not monitor individual #537 until 11:00 p.m., 40 minutes after notification of the restraint application. • Monitored and documented vital signs in five (100%). • Monitored and documented mental status in five (100%). Based on the documentation of restraint incidents above, in four of five (80%) incidents of restraints the nurse did not notify the physician provider. One nurse received retraining by the RN House Supervisor on the requirement to notify the provider(s) of incidents of restraint applications. Based on documentation provided by the Facility, zero restraints had occurred off the grounds of the Facility in the last six months. With regard to medical restraint please refer to Provisions C.4 and C.5. The Facility Section C Monitoring Report presented data from January, 2011 through February, 2012. This report showed a compliance rate for Provision C.5 averaging 95% since the last review by the Monitoring Team. The compliance rate for February, 2012 was 86%. Because of the low level of compliance observed by the Monitoring Team in key provisions of medical restraint policy implementation it is likely the Facility's compliance data is overstated. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	
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	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision: The self-assessment process included a review of monthly restraint audit compliance results for the months of October 2011 through January 2012 and a review of the Facility Quarterly Quality Assurance/Quality Improvement (QA/QI) restraint audit compliance results for September 2011 through November 2011 quarter and November 2011 through January 2012 quarter. The Facility's self-assessment reported the following:	Noncompliance

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	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.	Generally, audit results indicated that individuals were receiving the appropriate level of supervision for the type of restraint implemented, are checked for restraint related injuries, receive opportunities for exercise, fluids, food, and toileting, consistently. There is a need for improved documentation related to providing these opportunities and corrective action plans have included on-the-spot training provided to staff that make errors in documentation. Data reviewed from the September, October, and November 2011 quarter of restraint audit compliance results indicated compliance ratings of 99% for Provision C.6. One auditing error was noted related to fluids being given during restraint. The auditor was notified of the error and this was included in restraint auditor training conducted on 1/18/12. Data reviewed from the November and December 2011 and January 2012 quarter of restraint audit compliance results, indicated quarterly compliance ratings of 89.8% for Provision C.6. Results from the January 2012 restraint audit indicated there may be a need to more strictly audit medical/dental physical/mechanical restraints that occur during a sedation procedure. A more in depth review of physician's orders for correct format, to include the type and schedule of monitoring and correct codes for exercise, fluids, and toileting is needed to determine appropriateness for restraint. Based on the findings from this self-assessment the Facility determined this provision was not in substantial compliance because procedures related to Medical/Dental Sedation/Restraint are not being consistently implemented. <u>Monitoring Team Findings:</u> In the crisis intervention restraint sample reviewed by the Monitoring Team the rate of compliance was 100% in every category of this Provision. This review of crisis intervention restraints, along with the Facility's monitoring process to identify and correct documentation errors, was sufficient to merit a finding of substantial compliance with respect to crisis intervention restraint use. As noted in the Facility Self-Assessment, and validated in the Monitoring Team findings, compliance issues with respect to medical restraint use must be addressed for this provision to achieve a rating of substantial compliance. Refer to Provision C.4.	

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		A sample (Sample C.1) of five 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 five (100%), continuous one-to-one supervision was documented. • In five (100%), the date and time restraint was begun was documented. • In five (100%), the location of the restraint was documented. • In five (100%), information about what happened before, including the change in the behavior that led to the use of restraint was documented. • In five (100%), the interventions taken by staff prior to the use of restraint were documented and were adequate for post restraint review. • In five (100%), the specific reasons for the use of the restraint were documented. • In five (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated on the restraint checklist. • In five (100%), the names of staff involved in the restraint episode were indicated on the restraint checklist. Four of the restraints in the sample included use of the horizontal side-lying technique. In each of these restraint episodes at least two staff was listed as applying the restraint. • The Restraint Checklist documented observations of the individual and actions taken by staff while the individual was in restraint. All five (100%) restraint episodes were of short duration (recorded on the Restraint Checklist as one second, one minute, four minutes, five minutes, and 10 minutes); therefore some of the requirements of this provision (such as observations documented at least every 15 minutes) would not be applicable. • In five (100%), the specific behaviors of the individual that required continuing restraint were noted. • Because of the short duration of all five restraint episodes reviewed there was no obvious need for staff to provide, during the restraint, opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. • In five (100%), the level of supervision provided during the restraint episode was recorded on the restraint checklist. • In five (100%), the date and time the individual was released from restraint was recorded on the restraint checklist. • In five (100%), 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. In a sample of five records (Sample C.1), FFADs had been completed for five (100%). These forms were generally complete in checking all the required boxes on the form, supplemented with appropriate narrative. The attention to detail required to complete this documentation accurately had improved since the last review.	

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		A sample of nine instances of individuals who received medical restraint (pre-treatment oral sedation or TIVA) was reviewed. As noted in Provision C.4 and C.5 the documentation provided to the Monitoring Team was insufficient to validate that restraint use had been adequately documented. 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 Facility had a specific physician's order form that if completed correctly would capture this information. This form was not included in the documentation submitted to the Monitoring Team in 65% of the records in the samples. The Facility Section C Monitoring Report presented data from January, 2011 through February, 2012. This report showed a compliance rate for Provision C.6 averaging 83% since the last review by the Monitoring Team. The compliance rate for February, 2012 was 47%. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:	According to Facility documentation, during the six-month period prior to the on-site review, a total of three individuals were placed in restraint more than three times in any rolling thirty-day period. A sample of all three of these individuals (100%: Individuals #336, #337, and #381) was selected for review to determine if the requirements of the Settlement Agreement were met. The following documents were reviewed • ISPs, • ISP addenda, • IDT meeting minutes, • Psychological Assessment/Functional Assessment reports, • PBSPs, • PBSP progress notes, • SPCIs,	

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		• Physicians Orders for restraint, • Restraint Checklists, • Face-to-Face restraint debriefing forms The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. For three of the individuals/instances reviewed (100%), individuals' teams met to discuss the restraints.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	For none of the individuals/instances reviewed (0%), individuals' teams reviewed the individual's adaptive skills. For all three individuals in the sample, the IDT had discussed adaptive abilities. A review of each individual's record, however, revealed no formal assessment of adaptive abilities had been attempted in recent years. As a result, although discussions did take place, it was not possible that the discussions had involved objective and current information about the individuals' true abilities. For three of the individuals/instances reviewed (100%), individuals' teams reviewed the biological, medical and psychosocial factors. The following are example of individuals who whom this was done appropriately: • For Individuals #337 and #381, documentation reflected that the IDT met frequently, to review each individual's biological, medical, psychosocial status. • Individual #336 experienced serious medical problems during the review period and had been hospitalized. The documentation of IDT discussions consistently reflected consideration of the individual's medical condition.	Noncompliance
	(b) review possibly contributing environmental conditions;	For two of the individuals/instances reviewed (67%), individuals' teams reviewed the possibly contributing environmental conditions. The following are examples of individuals for whom this was done appropriately: • For Individual #337, a functional assessment was completed on 5/16/11. Documentation reflected that the functional assessment was routinely used as part of the restraint application review process. • 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 IDT recommended a new functional assessment on 11/30/2011. Although documentation provided conflicting information, the functional assessment was completed between 12/29/2011 and 1/11/2012. IDT	Noncompliance

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		restraint reviews did not reflect a discussion of functional assessment findings until late February 2012, at which time the IDT review indicated that no change in the function of the behavior resulting in restraint had been identified. A review of the latest functional assessment, however, revealed that the assessment was based upon ratings completed in July of 2011. Therefore, it was not possible that the latest functional assessment adequately addressed the referral of the IDT or the needs of the individual.	
	(c) review or perform structural assessments of the behavior provoking restraints;	For two of the individuals/instances reviewed (67%), 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 #337, a functional assessment was completed on 5/16/11. Documentation reflected that the functional assessment was routinely used as part of the restraint application review process. • 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 is an example of where teams failed to do this adequately: • For Individual #336, the IDT recommended a new functional assessment on 11/30/2011. Although documentation provided conflicting information, the functional assessment was completed between 12/29/2011 and 1/11/2012. IDT restraint reviews did not reflect a discussion of functional assessment findings until late February 2012, at which time the IDT review indicated that no change in the function of the behavior resulting in restraint had been identified. A review of the latest functional assessment, however, revealed that the assessment was based upon ratings completed in July of 2011. Therefore, it was not possible that the latest functional assessment adequately addressed the referral of the IDT or the needs of the individual.	Noncompliance
	(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	For three of the individuals reviewed (100%), the individual had a PBSP. Of the three individuals in the sample who had PBSPs, the following was found: • Two (67%) were based on the individual's strengths; • Three (100%) specified the objectively defined behavior to be treated that led to the use of the restraint; • Two (67%) specified the alternative, positive adaptive behaviors to be taught to	Noncompliance

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	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;	the individual to replace the behavior that initiates the use of the restraint; and • One (33%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. The following is an example of an individuals for whom an adequate PBSP was in place: • Individual #337 was provided a PBSP developed within the past year and based upon a functional assessment completed within the past year. The PBSP acknowledged that the individual was diagnosed with Lesch-Nyhan Syndrome, a medical condition associated with impulsive displays of extreme self-injury. In addition, however, the PBSP included strategies, such as the individual developing his personal daily schedule, that were likely to minimize displays of self-injury and promote independence. The following is an examples of an individual for whom the PBSP was inadequate: • Individual #336 was provided a PBSP. The PBSP was based, however, upon findings of a functional assessment completed prior to substantial environmental and health status changes that occurred in 2011. In addition, although the PBSP included procedures for teaching replacement behaviors, the individual had not demonstrated successful displays of the replacement behavior in several months. This suggested that this behavior was not effective for the individual in meeting personal needs and avoiding the use of self-injury. Despite this circumstance, a more effective replacement behavior had not been identified. The Safety Plans of the individuals in the sample were reviewed. The following represents the results: • 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.	
	(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	For none of the individuals reviewed (0%), the individual's behavioral data and/or treatment integrity checks showed that the PBSP was implemented with a high level of treatment integrity. At the time of the current site visit, the Facility indicated that treatment integrity checks were not consistently or routinely conducted.	Noncompliance

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	targeted behavior; and		
	(g) as necessary, assess and revise the PBSP.	In two of the records reviewed (67%), there was documentation that the individual's PBSP had been revised as appropriate. The following are examples of individuals for whom this was done appropriately: • For Individuals #337 and #381, the PBSP data reflected that the individuals were adequately maintaining skills and behaviors targeted by the PBSP. As a result, no revisions were necessary. The following is an example of where teams failed to do this adequately: • The PBSP for Individual #336 included procedures for increasing the use of communication devices to express personal desires. Data reflected that the individual had not successfully performed the replacement behavior in several months. The replacement behavior procedure, however, had not been revised prior to or following the annual ISP meeting in January 2012.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review 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.	Facility Self-Assessment: The Facility engaged in the following activities in conducting its self-assessment of this Provision: The self-assessment process included a review of monthly restraint audit compliance results for the months of October 2011 through January 2012; a review of the facility Quarterly Quality Assurance/Quality Improvement (QA/QI) restraint audit compliance results for September 2011 through November 2011 quarter, and November 2011 through January 2012 quarter; a review of IRT and IMRT meeting minutes for review of restraint within three business days from start of restraint (other than medical) for the past six months; and, a review of the occurrence/completion of Behavior Services restraint episode de-briefing process and document format during the past six months. The Facility's self-assessment reported the following: Restraint audit results for the past six months indicated consistently high compliance with the requirement for a review of restraint to occur within three business days. This review included a restraint debriefing conducted for crisis restraints within 15 minutes of the conclusion of restraint. The restraint episode, and related documentation was also reviewed in the unit IMRT the day after the restraint occurred. These two events consistently occur within three business days. IRT and IMRT minutes indicated a review of restraints occurs within three business days. On 2/3/12, the Director of Residential Services provided training to unit staff who conduct and prepare unit IRT's and their resulting meeting minutes. The training included a new section just below the listing of restraints for Notes of Discussion of Any Restraint. This discussion is to include any	Substantial Compliance

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		antecedents, reason for the restraint, any contributing environmental issues and any recommendations from the restraint review. This addition to the minutes was made to show the content of IRT discussion of restraint. The Behavior Services staff conducts debriefings of the restraint episode, which include interviewing staff implementing or present during the restraint. The results of the behavior services debriefing are reviewed at the unit IRT, and if necessary, at an individual's team meeting related to the use of restraint. Based on the findings from this self-assessment the Facility determined this provision was in substantial compliance because reviews of restraint use and the circumstances under which the restraint was used are occurring within three days and are substantive reviews as evidenced by compliance results for Provision C.8. The quarterly average compliance rating for Provision C.8 (for the months of September, October, and November 2011) was 97%. Compliance results for the months of December 2011 and January 2012 were both 100%. <u>Monitoring Team Findings:</u> The Monitoring Team selected a 20% sample of crisis intervention restraints (Sample C.1) that occurred from the time of the last review to the time of document preparation, a five-month period. During this time period the Facility reported 26 crisis intervention restraints involving 12 different people. The sample consisted of five restraints involving three different Individuals. The DSSLC process for reviewing each episode of restraint begins with a FFAD done by the restraint monitor immediately after the restraint episode. The restraint episode is reviewed in the unit morning meeting the next business day with whatever information has been prepared by the time of the meeting. This usually consisted 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. In most instances, the restraint use is also reviewed that same day by the Individual's IDT. The Monitoring Team reviewed documentation related to five incidents of crisis intervention restraint (Sample C.1). This documentation included the FFAD, Unit Morning meeting minutes, IMRT minutes, the Behavioral Services staff debriefing report, and ISP addendums resulting from the review process. Since the last review the Facility had modified the template for unit and IMRT meeting minutes to include a required entry described as "Discussion of any restraint to include antecedents, reason for restraint, any contributing environmental issues, and any recommendations from restraint review." This was done to prompt substantive restraint review. The Monitoring Team observed	

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		the Unit review meeting for both restraints that occurred during the week of the review. Restraint of Individual #21 occurred at 9:40pm on 4/3/12. The restraint of Individual #60 occurred at 8:39am on 4/4/12. This represented a 100% sample of Unit review meetings of restraints that occurred during the review week. Both individuals lived on the same unit and both restraints were reviewed in the Unit morning meeting held on 4/5/12. The unit meeting to review these two restraints was observed by the Monitoring Team. The meeting was led by the Unit Director and the restraint discussion was led by the unit's Behavior Analyst. The discussion was interdisciplinary, included data review, and through the interdisciplinary discussion led to suggested changes in each Individual's Positive Behavior Support Plan and ISP. In the case of Individual #21 the IDT was scheduled to meet on 4/6/12 to formally address the issues presented in the Unit morning meeting. In the case of Individual #60 the IDT was scheduled to meet on 4/4/12 to formally address the issues presented in the Unit morning meeting. Documentation of these reviews, and referral to the respective IDTs, were noted in the Unit morning meeting minutes for 4/5/12. The IMRT also reviewed each restraint within three working days of the restraint. The IMRT review for Individual #21 occurred on 4/6/12 and the IMRT review for Individual #60 occurred on 4/4/12. Documentation of these reviews were noted on IMRT minutes for these dates. Sample C.1 documentation reviewed by the Monitoring Team showed that: ▪ In five (100%), the review by the Unit IDT occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist and FFAD. ▪ In five (100%), the review by the IMRT occurred within three business days of the restraint episode and this review was documented in IMRT minutes. ▪ In five (100%), the circumstances under which restraint was used was determined and was documented on the Face-to-Face Assessment Debriefing including the signature of the staff responsible for the review. A further review was completed by staff from the Behavioral Services Department and documented on the Behavioral Services Debriefing report. When appropriate this review included review of video surveillance recordings. ▪ In five (100%), the review conducted by the Unit IDT and the IMRT was sufficient in scope and depth to determine if the application of restraint was justified, if the restraint was applied correctly, and to determine if factors existed that if modified might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful, or were not attempted because of the emergency nature of the behavior that resulted in restraint. ▪ In five (100%) of Sample C.1, the review conducted by the Unit IDT and the IMRT resulted in an additional referral to the IDT for review and consideration of	

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		possible changes in active treatment plans, positive behavior plans, and other aspects of the ISP that effect the behavior of the individual; and ▪ Of the five referred to the team, five (100 %) resulted in changes made to the individuals' ISPs and these changes appeared appropriate to the circumstances. For example, Individual #537's IDT met after a restraint on 1/17/12 and initiated six very specific actions to be taken that the team felt would reduce the likelihood of restraint use in the future. Restraint procedures used across the Facility were also reviewed at the monthly Restraint Reduction and Behavior Support Committees. The meetings of each group observed by the Monitoring Team (and a review of previous meeting minutes) confirmed that meetings were substantive in nature and included both policy and procedural discussions. Meetings were well attended and discussions were interdisciplinary. It was evident these committees engage in substantive review, problem solving, and the development of specific recommendations. Meetings often included a case study, which was typically the most difficult behavioral/restraint case at the time of the meeting. Additionally, the Quality Assurance/Quality Improvement Council included 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 did ensure a broader base of general review of restraint data and restraint practices at the DSSLC. The Facility Section C Monitoring Report presented data from January, 2011 through February, 2012. This report showed a compliance rate for Provision C.8 averaging 92% since the last review by the Monitoring Team. The compliance rate for December, 2011 and January, 2012 was 100%. For February, 2012 the compliance rate was 83%. The last three months reported a compliance rate average of 94%. The Monitoring Team concurs with the Facility self-assessment of substantial compliance. The Monitoring Team reviewed Unit team meeting minutes, IMRT meeting minutes, IDT meeting minutes (ISPA's), and psychology department review minutes for each of the restraints in the sample. From the meetings attended, and the documentation reviewed, it was evident to the Monitoring Team that the Facility had a restraint review process sufficient to demonstrate compliance with C.8. Additionally, the Facility's self-assessment reported a high degree of compliance and this was confirmed by the Monitoring Team in its review of documents, interviews with staff, and observation of meetings.	

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 and C.3).

2. Monitoring of implementation of medical restraints needs to be more rigorous (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. Structural and Functional Assessments should be updated as needed, and current information should be used when considering revisions to PBSPs for individuals who have had several restraints. (Provision C.7)
6. Especially for individuals experiencing restraint, treatment integrity checks should be done to ensure PBSPs are implemented accurately (Provision C.7)
7. 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. Ensure the auditing/monitoring activity that is producing compliance reports accurately reflects compliance performance. Use these data to initiate process improvements.
2. Continue the practice of immediate retraining of staff as auditors/monitors discover issues.
3. 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 Self-Assessment 3/16/12 2. DSSLC Action Plan 3/8/12 3. DADS Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation 5/11/11 4. DADS Policy 02.3 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 DSSLC's quarterly meeting with Department of Family and Protective Services (DFPS) 1/12/12 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 3/1/12 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 9/27/11 14. DSSLC report on volunteer background checks 4/3/12 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 12/9/11, 12/16/11, 12,23/11, 12/30/11, 1/6/12, 1/13/12, 1/20/12, 1/27/12, 2/3/12, 2/10/12, 2/17/12,and 2/24/12 20. Allegation, Injury, and UIR Trend Report 2/12 21. Individual Training Records for Facility and Department of Family and Protective Services (DFPS) Investigators 22. DFPS case log 9/2/11 to 4/2/12 23. OIG case log 9/2/11 to 4/2/12 24. Local law enforcement log 9/2/12 to 4/2/12 25. Log of employees reassigned from client contact 11/1/11 to 3/1/12 26. List of employees not hired because of background checks 27. List of employees terminated due to background checks 28. Serious Injury log 9/2/11 to 4/2/12 29. Witnessed Injury log 9/2/11 to 4/2/12

	30. List of the most frequently injured Individuals 9/2/11 to 2/28/12 31. Discovered Injury log 9/2/11 to 4/2/12 32. Serious Incidents log 9/2/11 to 4/2/12 33. Peer caused injury log 2/27/11 to 2/27/12 34. Discovered Injury Investigation for Individuals #144, #295, #334, #422, and #573 35. UIRs related to DSSLC serious injury investigations: 041, 086, 095, and 101 36. Other UIRs: 025, 061, 070, and 079 37. DFPS Investigation files for compliance review sample: 40452496, 40530892, 40628692, 40677457, 40861876, 41025956, 40881836, 40964307, 41016516, 41158676, and 41285018 38. Additional DFPS Investigation files: 40385905, 40689796, 40832698, 40948818, 41169476, 40304118, and 41608353 39. DFPS cases referred back to the Facility: 40294088, 40301496, 40474636, 40484217, 40530892, 40628692, and 41012475 40. List of employee late reporting 41. Under Reporting Audit reports October, 2011 - March, 2012 42. Rights Poster Audit reports October, 2011 – March, 2012 43. Self-Advocacy meeting minutes: 10/28/11, 11/18/11, 12/30/11, 1/27/12, and 2/24/12 44. QA/QI committee meeting minutes: October, 2011 through March, 2012 **People Interviewed:** 1. Deb Salsman, Director of Incident Management 2. Jeron Dotson, Incident Management Coordinator 3. Simona Armendariz, DFPS Investigator **Meetings Attended/Observations:** 1. Incident Management Team (IMRT) 4/2/12 2. Facility Review Authority 4/2/12 3. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 4/3/12
	Facility Self-Assessment: There are 22 Provisions or components of Provisions in Section D of the SA. The DSSLC self-assessment reported substantial compliance with 20. The Monitoring Team determined substantial compliance with only 12. Only one complete Provision was found in substantial compliance. This was Provision D.5 which addressed required background checks of employees and volunteers. Many of the noncompliant areas were the result, directly or indirectly, of late reporting of serious incidents, and incident and injury investigations that were insufficient in scope and depth and drew questionable conclusions. The Facility's investigation report review process was not detecting what to the Monitoring Team were fairly obvious flaws with investigation methodologies, and in some cases conclusions. The self-assessment conducted by the Facility lacked detail and comprehensiveness. For example, many sections did not address each element of each Provision or component of a Provision. The Facility's self-assessment process was overly general. Future self-assessments should be more descriptive. For example, this self-assessment often stated "The review of 20 cases from November 2011 to

	February 2012 showed that…." The self-assessment should describe what type of cases (e.g. DFPS investigations and if so what type, serious injuries, discovered injuries, serious incidents, etc.), how the cases were reviewed, whether or not the review activity is recorded on some sort of worksheet, whether or not QA monitoring data was also used to determine the status of compliance, and consideration of other relevant data. The Facility's Action Plan that accompanies the self-assessment included steps to improve processes that were intended to lead to compliance with the Settlement Agreement. Similar to the Self-assessment, the Action Plan also lacked detail and comprehensiveness and was overly general. For example, an Action Step was described as "Center Director to be notified immediately of all serious injuries." This is an expected outcome of one or more action steps. This is not a description of an action step. Future action plans need to address action steps, not merely expected outcomes. Additional action steps will need to be developed to address issues identified by the Monitoring Team which are not sufficiently addressed in the current Facility Action Plan.
	Summary of Monitor's Assessment: The Facility was found to be in substantial compliance with 12 Provisions/components of Provision requirements in the Settlement Agreement and does many things well. For example, the Facility demonstrated 100% compliance with the staff training requirements associated with abuse, neglect, and exploitation, and unusual incidents. Additionally, staff tested by the Monitoring Team had retained the knowledge learned in class. Random staff was given the same competency test used in annual refresher training. All answered all questions correctly. Reporting procedures were prominently displayed throughout the Facility and are printed on the back side of employee identification badges. In every instance where an alleged perpetrator (AP) was known the AP was immediately placed in no direct contact status. The Monitoring Team did not discover any instance of a mandatory reporter failing to report abuse or neglect. Several instances of late reporting were noted. In all allegations of physical abuse in the sample drawn by the Monitoring Team, law enforcement notification occurred. Compliance with required background checks was confirmed. There are areas in need of improvement and increased oversight by Facility leadership staff. 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. The processes in place at

	the Facility are insufficient to accomplish this. The Facility needs to improve its internal review systems, including its self-assessment procedures, to accurately identify all instances of late reporting. The frequency of untimely reporting is unacceptable and erodes the Facility's commitment to a lack of tolerance of abuse and neglect. The training transcript for one DFPS investigator did not document completion of required training. On 4/3/12 the Facility was informed of this training deficiency and given the opportunity to produce additional documentation by the end of the review on 4/6/12. None was provided. This person was the investigator for 38% of the investigations sampled by the Monitoring Team. The Facility had very limited mechanisms to prevent the potential contamination of testimonial evidence. This may have affected one or more investigations. The Facility, along with DFPS, needs to establish a methodology that can reasonably protect testimonial evidence. Investigations sampled by the Monitoring Team were not always adequately initiated within 24 hours of the report of the incident. DFPS investigation reports reviewed were not always sufficient in scope and depth to provide a clear basis for investigation conclusions. Facility investigation reports reviewed were not always sufficient in scope and depth to provide a clear basis for investigation conclusions. Concerns with investigation reports identified by the Monitoring Team that should have been detected by the DFPS supervisory review process were not. Concerns with investigation reports identified by the Monitoring Team that should have been detected by the Facility review process and reported back to DFPS to correct deficiencies or complete further inquiry were not. An area still in need of improvement is tracking data on the results and outcomes of incidents and investigations, by type (e.g. Physical abuse Class I, Class II, Neglect, etc.), including data that can tell the Facility, for example, if the frequency of confirmed and/or inconclusive findings is increasing or decreasing. Trend data should be presented in a manner that lends itself to useful discussion and decision-making.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision:	Substantial Compliance

	require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The self-assessment process included a review of local policies that address Abuse and Neglect (ANE) to determine if zero tolerance commitment and staff reporting responsibilities are included. The Facility's self-assessment reported that local policies clearly include the Facility's commitment to zero tolerance of ANE. Based on the findings from this self-assessment, the Facility determined that this Provision remained in substantial compliance because the local policies address the commitment of zero tolerance of ANE. Note: the Facility's self-assessment was incomplete as it did not address all required elements of the SA, for example reporting requirements. <u>Monitoring Team Findings:</u> 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. To test staff knowledge of abuse/neglect reporting responsibilities the Monitoring Team met with three staff from the morning shift and three staff from the afternoon shift. All were given the same competency test used in annual refresher training. All six staff answered all questions correctly. Additionally, reporting procedures were prominently displayed throughout the Facility and were printed on the back side of employee identification badges. Timely reporting of allegations was problematic at the DDSLC. The Facility self-assessment in Provision D.2 reported "three recent incidents of late reporting" to the Director of serious incidents. The document request provided to the Monitoring Team noted five instances of late reporting (11/4/11, 11/8/11, 12/28/11, 2/8/11, and 2/27/11). In each case it was noted that applicable staff were retrained in abuse and neglect reporting requirements. In reviewing Sample C.2 (facility investigations of serious injuries) the Monitoring Team discovered an additional instance of late reporting to the Director. UIR 041 (11/5/11) reports an injury occurring at 5pm on 11/5/11. Page three of the UIR indicated this serious injury was reported to the Director designee at 8pm on 11/6/11. The Facility needs to ensure its internal review systems, including its self-assessment procedures, accurately identify all instances of late reporting. An additional measure of a facility's commitment to zero tolerance is its review and	

		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 an injury. The Facility had experienced 395 non-serious discovered injuries between 9/27/11 and 4/2/12. The Facility's investigation of these discovered injuries were inadequate to make a determination that abuse and neglect could be ruled out as a cause, or a contributing factor, of the injury. Please refer to Provision D.2.a for additional discussion of this topic. While Facility policy requires that staff report (and report timely) allegations of abuse, neglect, and other serious incidents, consistent implementation of timely reporting needs to be addressed. The frequency of untimely reporting is unacceptable and does not demonstrate sufficient commitment to no toleration of abuse and neglect. The Monitoring Team has determined that the DSSLC was in substantial compliance with this provision of the SA, as there were no instances of lack of reporting, staff competency had been retained since training, and the Facility had taken action on late reporting. During this visit, additional factors that would demonstrate commitment to zero tolerance, such as the frequency of timely reporting and the process for review of discovered injuries, were reviewed and considered by the Monitoring Team. Although the Facility remained in compliance with the requirements of this provision, the Monitoring Team encourages the Facility to track occurrence of late reporting and to initiate corrective actions if improvement does not occur, and to review more carefully non-serious discovered injuries to identify possible contributions of abuse or neglect.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision: The self-assessment process included a review of cases to see if staff reported ANE and serious injuries to the director or designee according to policy. The Facility's self-assessment reported the following. The review of 20 cases from November 2011 to February 2012 showed that 18 of 20 (90%) had been reported to the	Noncompliance

	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.	Director according to policy. Based on the findings from the self-assessment the Facility determined that this Provision was not in substantial compliance even though the Facility had a 90% compliance rate. Audits showed that the Director had not been notified of all incidents immediately. Recently there were three incidents that were not reported to the Director. Additional training had been provided to all staff involved. <u>Monitoring Team Findings:</u> 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 10/1/11 through 3/31/12. During this six month period allegations reported to DFPS were as follows: 1. 107 abuse allegations. The disposition by DFPS of these 107 allegations was: 14 were substantiated, 70 were unconfirmed, six were inconclusive, 14 were referred back to the Facility as the allegation did not meet DFPS criterion for investigation. Three were listed as disposition pending. 2. 74 Neglect allegations. The disposition by DFPS of these 74 allegations was: 1 was substantiated, 23 were unconfirmed, none were inconclusive and 47 were referred back to the Facility as the allegation did not meet DFPS criterion for investigation. Three were listed as disposition pending. 3. Four exploitation allegations. One was referred back to the Facility as the allegation did not meet DFPS criterion for investigation. Three were listed as disposition pending. Note: The above data represents individuals who were alleged to have been abused or neglected. It does not represent the number of DFPS cases as a case may have multiple alleged victims. Two samples of investigations were selected for review. These included: • Sample D.1 of 10 DFPS investigations of abuse, neglect, and/or exploitation between 9/2/11 and 3/7/12. This sample included the following DFPS investigation reports: 40452496, 40530892, 40628692, 40677457, 40861876, 41025956, 40881836, 40964307, 41016516, 41158676, and 41285018. This represented a 20% sample of cases. The sample was selected by working back from the most recent investigation and selecting two cases of confirmed physical abuse, two cases of unconfirmed physical abuse, two cases of unconfirmed	

		neglect, two cases with inconclusive findings (both allegations of abuse) and two allegations of neglect referred back to the Facility. Because two of the cases in the sample were administrative referral, analysis in this report will refer to the eight allegations subject to a complete investigation. • Sample D.2 of four facility investigations of serious injuries. DSSLC provided a report entitled Serious Injury Report, which listed serious injuries to individuals from 9/2/11 to 3/7/12. From this report the Monitoring Team was able to determine the DSSLC had 21 serious injuries during this time period. From these 21, four (20%) were selected for Sample D.2 to assess the adequacy of the facility investigation process. Three of those selected were discovered injuries and one was a witnessed injury. In reviewing Sample D.1 (DFPS case reports) two of the eight investigations noted a date and time the incident occurred (the other eight noted "unknown" although four noted a date the reported incident occurred but noted the time of the incident as unknown). Both investigations that noted the date and time an incident occurred were reported to DFPS within one hour of discovery as required by policy. In reviewing Sample D.2 (serious injuries) two of four (50%) were reported immediately (within one hour) to the Facility Director/designee. Those that were not reported within one hour were UIRs 041 and 095. While the Facility self-assessment reported three recent incidents of late reporting to the Director of serious incidents, the document request provided to the Monitoring Team noted five instances of late reporting (11/4/11, 11/8/11, 12/28/11, 2/8/11, and 2/27/11). In each case it was noted that applicable staff were retrained in abuse and neglect reporting requirements. In reviewing Sample C.2 (facility investigations of serious injuries) the Monitoring Team discovered an additional instance of late reporting to the Director. UIR 041 (11/5/11) reported an injury occurring at 5pm on 11/5/11. Page three of the UIR indicated this serious injury was reported to the Director designee at 8pm on 11/6/11. The Facility needs to ensure its internal review systems, including its self-assessment procedures, accurately identify all instances of late reporting. 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 an injury. The Facility had experienced 395 non-serious discovered injuries between 9/27/11 and 4/2/12. The Monitoring Team reviewed a sample of five Discovered Injury Investigation Worksheets and identified several issues that suggest investigations of non-serious injuries were not conducted with sufficient scope and depth to allow for a reasonable	

		conclusion to rule out abuse or neglect as a cause or contributing factor of the injury. For example, in the staff interview section of each worksheet, the shift of the person being interviewed was noted. It was not possible to determine if the person being interviewed was actually working the shift that the injury was discovered on and/or the day prior to discovery. Without this information it would not be possible to determine if the interviewee would be expected to have relevant information regarding the Individual's activity and interaction with peers and staff in the hours preceding discovery of the injury. The interview response recorded on each worksheet almost always provided a statement by the interviewee of a hypothesis for the cause of the injury such as "maybe he scratched himself", "may have stumbled getting out of bed", "possibly got upset and hit his elbow on the wall in the hallway", "may have sat on seatbelt in the wheelchair", and "may have bumped her leg." The person conducting the interview should be gathering objective information that reflects relevant information regarding the Individual's activity and interaction with peers and staff in the hours preceding discovery of the injury, including trying to determine the last time the Individual was noted to not have the injury. The purpose of an interview should be to establish what staff and peers were doing, where they were located, what they saw, what they heard, etc. Data collected in this manner can more appropriately be used to reasonably rule out abuse/neglect. Other issues noted in the review of sampled Discovered Injury Investigation Worksheets included a lack of required information on the worksheet, for example a "yes" entry responding to the query "does the Individual have a BSP?" but no indication of what the targeted behaviors are, as required by the worksheet format (Individual #422); and, inaccurate information on the worksheet, for example in response to the query "what does the review of the one year injury history reveal" one worksheet reported "no other injuries of this type." A quick review of the injury history provided as part of the documentation file for the Monitoring Team showed this Individual had four similar injuries in the last year (Individual #422). Finally, it was not always possible to determine who conducted the investigation, what their job title was, or the date of the investigation. One worksheet (Individual #573) had no name, title, or date noted on the worksheet. One worksheet (Individual #144) had the name and date, but not the staff person's job title. Another (Individual #295) had the person's name but no date or job title. These investigations are conducted by unit staff, and the worksheet and any related documentation are apparently not reviewed external to the residential unit. It was apparent to the Monitoring Team that little review of these investigations occurred by anyone. 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. The Monitoring Team concurs with the Facility self-assessment of noncompliance.	
	(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.	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision: The self-assessment process included a review of Alleged Perpetrators (AP) reassignment log to determine that all alleged perpetrators were not in direct contact with individuals until the investigation was completed. The Facility's self-assessment reported the following. The reassignment log shows that 100% all alleged perpetrators were removed from direct contact with individuals until the investigation was complete. Based on the findings from this self-assessment the Facility determined that this Provision remained in substantial compliance because the log shows that a 100% of all alleged perpetrators have no direct contact with individuals until the investigation is complete. <u>Monitoring Team Findings:</u> Based on a review of the eight investigation reports included in Sample D.1, in every instance where an alleged perpetrator (AP) was known the AP was immediately placed in no direct contact (NDC) status. Additionally, the Monitoring Team was provided with a log of employees who had been reassigned since 11/1/11. 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. With respect to the Facility self-assessment of this requirement a review of a log is insufficient to self-assess compliance. A more appropriate methodology would be to review a sample of UIR's to determine if the UIR reported reassignment to NDC status. This could also include a review a sample of time and attendance records to determine if these records can validate the reassigned employee worked at the reassigned location and not at the residential unit or in other locations that could involve direct contact. Finally, the Facility should understand the relationship between late reporting (refer to Provisions D.1 and D.2.a) and this SA requirement. When late reporting occurs this can impact the Facility's ability to immediately remove alleged perpetrators from direct care responsibilities and as a result place Individuals at unnecessary risk. Each instance of late reporting detected by the Facility's internal review processes should assess this	Substantial Compliance

		potential with respect to compliance with this Provision. Review of eight 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. This conclusion was reached by reviewing the UIR that accompanied each DFPS investigation. Based on a review of the eight 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 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.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision: The self-assessment process included a review of the training compliance report from the Competency Training Department (CTD). The Facility's self-assessment reported the following compliance rates: October 2011 98% November 2011 99% December 2011 100% January 2012 99% February 2012 99% Based on the findings from this self-assessment, the Facility determined that this Provision remained in substantial compliance because an average of the percentages for the above listed months reflects a 99% compliance rate. Note: the Facility's self-assessment was incomplete as it did not address all required elements of the SA, for example a review of training curriculum to determine that it was or was not competency based. <u>Monitoring Team Findings:</u> 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 Incidents at least yearly. These two classes are sufficient to demonstrate compliance with	Substantial Compliance

		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 constituted 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 all 25 (100%) 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. To test staff knowledge of abuse/neglect reporting responsibilities the Monitoring Team met with three staff from the morning shift and three staff from the afternoon shift. All were given the same competency test used in annual refresher training. All six staff answered all questions correctly. 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 Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision: The self-assessment process included a review of Acknowledgement of Responsibility for Reporting Abuse, Neglect and Exploitation forms. The Facility's self-assessment reported the following. Reviewed 16 forms (Random Sample) from November 2011 to February 2012. Sixteen of 16 (100%) were signed and acknowledged by staff. Based on the findings from this self-assessment, the Facility determined that this Provision remained in substantial compliance because 100% of staff had signed Acknowledgement forms. Note: the Facility's self-assessment was incomplete as it did not address all required	Substantial compliance

	neglect.	elements of the SA, for example a review of data to determine if any mandatory reporter failed to report, and if so, whether appropriate personnel action was taken. Monitoring Team Findings: 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, 88 of 88 (100%) 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-five of 25 (100%) had current signed 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. Several instances of late reporting were noted in Section D.1 and D.2.a of this report. One was not identified by the Facility through its management review process of incidents. Consequently, no personnel action was taken in that 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.	Facility Self-Assessment: The Facility engaged in the following activities in conducting its self-assessment of this Provision: The self-assessment process included a review of the ISP packet sent to family members and reviewed cases to see if individuals/ family members had reported ANE. The Facility's self-assessment reported the following. Twenty of 20 ISP packets sent to Family members from November 2011 to February 2012 were reviewed, and 20 of 20 contained information about reporting and preventing abuse as well as what signs to look for. A review by the Facility of 20 cases from November 2011 to February 2012 showed that twenty of 20 (100%) individual's had self-reported ANE and one family member had reported ANE. The Monitoring Team is concerned that the self-assessment data used by the Facility for this Provision is questionable. It is highly unlikely that a random sample of 20 cases would result in all 20 investigations having resulted from allegations	Substantial Compliance

		reported by Individuals living at the Facility or their LAR or family members. Based on the findings from this self-assessment, the Facility determined that this Provision is in substantial compliance because the family members receive information on how to report and prevent and look for signs of ANE, and out of 20 cases 100% were self-reported by the individual. <u>Monitoring Team Findings:</u> Facility activity directed at compliance with this Provision included: • Educational materials were provided to LARs and Individuals prior to each individual's ISP meeting. • QDDPs individually reviewed the provisions of abuse and neglect reporting with Individuals prior to their ISP meeting. • The topic of rights, including abuse and neglect were a regular part of each self-advocates meeting. In reviewing Facility data the Monitoring Team identified 28 instances since the last review where allegations of abuse or neglect had been reported by Individuals living at the Facility and one allegation that was reported by a family member. This suggests the educational efforts undertaken by the Facility are achieving their intended purpose. Monitoring Team members attended three ISP meetings in the course of the review. These were for Individuals #1, #53, and #464. In one, Individual #53, information was provided at the ISP meeting regarding abuse/neglect reporting procedures. Doing this consistently 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.	
	(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.	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision. The self-assessment process included a review of audits from the quality assurance auditor to determine whether the rights posters were posted in all living areas and program areas. The Facility's self-assessment reported the following. The review of audits from November, 2011 to February, 2012 showed that twenty of 20 (100%) reflect that the rights posters are posted and easily understood. Based on the findings from this self-assessment, the Facility determined that this Provision remained in substantial compliance because the Facility had 100% of the	Substantial compliance

		posters posted in each living unit and day program according to policy. Monitoring Team Findings: 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 postings of individuals' rights where in areas to which individuals regularly had access. The Facility had laminated posters and/or used frames to ensure the posted notices remained 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 the period of 10/1/11 through 3/31/12 and reported 100% compliance. The Monitoring Team has determined that the DSSLC was in substantial compliance with this component of the SA.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	Facility Self-Assessment: The Facility engaged in the following activities in conducting its self-assessment of this Provision: The self-assessment process included a review of cases to ensure that law enforcement had been notified of all cases of ANE. The Facility's self-assessment reported the following. A review of 20 cases (random sample) from November, 2011 to February, 2012, showed that in twenty of 20 (100%) law enforcement was notified in all cases reviewed. Based on the findings from this self-assessment, the Facility determined that this Provision was in substantial compliance because in all cases where law enforcement needed to be notified, notification was made. Monitoring Team Findings: 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. 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. In all allegations of Physical Abuse in Sample D.1 law enforcement notification occurred.	Substantial Compliance

		Based on a review of four 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. The Monitoring Team has determined that the DSSLC was in substantial compliance with this component of the SA.	
	(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.	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision. The self-assessment process included a review of cases for potential retaliation. The Facility's self-assessment reported the following. In 20 cases (random sample) from November, 2011 to February, 2012, there were no instances of retaliation reported or discovered. Based on the findings from this self-assessment, the Facility determined that this Provision remained in substantial compliance because no there have been no instances of retaliation <u>Monitoring Team Findings:</u> Based on interviews with the 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. 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	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision. The self-assessment process included a review of under reporting audits	Noncompliance

	reported for investigation.	completed by the quality assurance auditor to determine whether injuries to individuals were reported for investigation. The Facility's self-assessment reported the following compliance rates. November 95% December 90% January 92 % Based on the findings from this self-assessment, the Facility determined that this Provision remained in substantial compliance because the average of percentages for the above listed months for under reporting reflects a 92% rate, and audits are completed on a monthly basis. Note: the Facility's self-assessment was incomplete as it did not address all required elements of the SA,; for example, the Facility audits detected issues with injury documentation but did not provide specific data on significant injuries that were not reported or whether such significant injuries were reported for investigation. <u>Monitoring Team Findings:</u> The Facility had a regular audit process in place to detect instances of unreported injuries. The auditor reviewed individual records, especially nursing 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 were reconciled. Results of these audits were reviewed by the Monitoring Team for the period 10/1/11 through 3/1/12. The data reported by the Facility reported a compliance rate of 94%. The Facility self-assessment reported a compliance rate of 92%. A review of data by the Monitoring Team determined a compliance rate of 86%. Facility monthly reporting (from the QA auditor to the QA Director) showed a total of 78 records having been audited. There were 11 instances of problems (14% of 78) identified in the individual audits. More significant than these data inconsistencies is that the process in place at the DSSLC did not address the requirements of this provision. The audit process detects injuries that were not properly documented. The process, in its current state, did not: • Determine whether or not the issue identified by the program auditor is representative of a "significant injury". A significant injury may not necessarily be a serious injury as defined in DADS or Facility policy. For example, several of the issues identified in the audits involved incidents/injuries that reported coughing (i.e. aspiration issue?), cuts (i.e. blood and infection control issue?), and	

		injury in the area of the eye (client protection issue?). All these could be considered "significant" and should have been more closely scrutinized. The Facility did not have a process to identify any underreporting of such significant injuries. • Determine whether or not the issue identified by the program auditor was (or should have been) reported for investigation. • Determine that if the issues identified by the program auditor should have been reported for investigation, and were not, that discovery of this resulted in initiation of an investigation. Furthermore, the Facility had experienced 395 non-serious discovered injuries between 9/27/11 and 4/2/12. The Facility's investigation of these discovered injuries were inadequate to make a determination that abuse and neglect could be ruled out as a cause, or a contributing factor, of the injury. One element of this component of this provision is to identify significant injuries that should have been reported for investigation and validate they had. The process in place at DSSLC does not accomplish this. An additional purpose of a semi-annual audit of injuries is to ensure that patterns of non-serious injuries that might raise suspicion of abuse or neglect are identified and subject to investigation. This requires review and analysis of Facility data. Such an audit might analyze six-months of injury data and identify individuals with large numbers of non-serious injuries that could raise suspicion, such as falls, or peer caused injuries. Data analysis could determine if a significant number of these injuries occur when a certain staff person is on duty, or they occur at a certain location, or any other variable determined to be potentially significant. This data analysis (i.e. a semi-annual audit) could determine that a formal investigation should be initiated. This data analysis might also point to systemic issues that might need to be explored in more detail, perhaps using root cause analysis methodologies. While the DSSLC is to be commended for the audit system of individual record review it has put in place, the Facility needs to initiate audit/review activity that is broader in scope. The Monitoring Team has determined that the DSSLC was not in substantial compliance with this component of the SA. The Facility had received a compliance rating of substantial compliance in the last review based on its auditing procedure. Additional administrative and quality assurance measures, as described above, need to be put in place to achieve full compliance with the SA requirements.	
D3	Commencing within six months of		

	the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision: The self-assessment process included a review of staff training records to determine all staff conducting investigations per state and local policy completed required training. The Facility's self-assessment reported the following. On February 22, 2012, review of staff training records indicated all staff (100%) that conduct investigations are properly trained. Based on the findings from this self-assessment, the Facility reported that this Provision remains in substantial compliance because all staff that conduct investigations received the training required by State and local policy. Note: the Facility's self-assessment was incomplete as it did not address all required elements of the SA; for example, it is not clear if the Facility's self-assessment reviewed training curriculum and training completion for DFPS investigators, and, the Facility's self-assessment did not address the requirement that investigators are not within the direct line of supervision of the alleged perpetrator. <u>Monitoring Team Findings:</u> 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	Noncompliance

		training, if completed as described, should be adequate for the conduct of investigations at DSSLC. Finally, the Facility policy required that investigators be outside of the direct line of supervision of 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 the Monitoring Team is of the opinion that this training was competency-based. 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 six investigators assigned to work DSSLC cases. The training records for these investigators were reviewed. Five of the six (83%) had completed the requirements for investigations training. The training transcript for one investigator did not document completion of BSD1 & 2, or ILSD and ILASD. On 4/3/12 the IMC was informed of this training deficiency and given the opportunity to produce additional documentation by	

		the end of the review on 4/6/12. No additional documentation was provided. This investigator was the investigator for three of the eight (38%) investigations conducted pursuant to Sample C.1. Note: two cases in the sample were administrative referrals and did not include a full investigation by a DFPS investigator. DSSLC had nine staff designated as investigators. The training records for these staff 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 not in substantial compliance with this component of the SA because 38% of the DFPS investigations in Sample C.1 were conducted by an investigator for whom adequate documentation of training was not provided to the Monitoring Team. The Facility had received a compliance rating of substantial compliance in the last review.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision. The self-assessment process included a review of cases(random sample) to determine if staff cooperated with outside entities during investigations. The Facility's self-assessment reported the following. The review of 20 cases from November, 2011 to February, 2012 indicated 20 of 20 (100%) showed that staff cooperated with outside entities during ANE investigations. Based on the findings from this self-assessment, the Facility determined that this Provision remains in substantial compliance because there were no instances where staff did not cooperate with outside entities conducting investigations. The Facility self-assessment could be improved by having someone from outside the IMC office (e.g. QA) interview a DFPS and/or OIG investigator to review the level of cooperation exhibited by DSSLC administrative, incident management, and direct care staff. <u>Monitoring Team Findings:</u> The Monitoring Team did not find any instances of lack of cooperation in its review of the 10 DFPS investigations in Sample D.1. Additionally, the Monitoring Team interviewed one DFPS investigator who reported excellent levels of cooperation by facility staff.	Substantial Compliance

		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: • 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. • 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. • 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 interview.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision. The self-assessment process included a review of the local policy to determine that policy supports the coordination of investigations and conducted a review of cases to determine investigations were coordinated appropriately. The Facility's self-assessment reported the following. A review of local policy shows that policy supports appropriate coordination of investigations between agencies and a review of 20 cases(random sample) from November, 2011 to February, 2012 reflect 20 of 20 cases (100%) showed that investigations were coordinated appropriately. Based on the findings from this self-assessment, the Facility determined that this Provision remains in substantial compliance because all of the reviewed cases were coordinated appropriately. The Facility self-assessment could be improved by Facility staff interviewing an OIG investigator specifically about coordination with DFPS and the Facility, and interviewing a DFPS investigator specifically about coordination with OIG and the Facility. <u>Monitor Team Findings:</u> 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	Substantial Compliance

		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 10 investigations completed by DFPS and the companion UIRs completed by 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.	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision. The self-assessment process included a review of local policy to ensure it supports the safeguarding of evidence and a review of cases to determine if evidence was safeguarded if needed. The Facility's self-assessment reported the following. Evidence is being safeguarded according to policy. Only the Director of IM and the IMC have keys to the evidence cabinet and it is locked in IMC office. The review of a random sample of 20 cases from November, 2011 to February, 2012 indicates 20 of 20 cases (100%) had no evidence to secure. Based on the findings from this self-assessment, the Facility determined that this Provision remains in substantial compliance because there was no physical evidence to safeguard or evidence was safeguarded per policy. <u>Monitor Team Findings:</u> Exhibit B to policy CMGMT 01B Incident Management (7/1/11) provides specific guidelines for safeguarding physical evidence. While on site, the Monitoring Team observed the area the Facility uses for safeguarding physical evidence in the locked office of the Incident Manager's office. Based on a review	Substantial Compliance

		of the investigations completed by DFPS (Sample D.1) and the Facility (Sample D.2) any physical evidence that needed to be safeguarded was. The Monitoring Team has a concern with the protection of testimonial evidence. As noted in Provision D.3.e of this report it is not uncommon for the interview process of alleged perpetrators and collateral witnesses not to begin until several days after an allegation has been reported to DFPS. This can diminish the accuracy of testimonial evidence. In fact, the training curriculum DFPS uses in training its investigators (Module 7 of DFPS Facility Investigations ILSD training, page 7-2) states "Interviews should be done as soon after the incident as possible, while witness' memories are still fresh. (Research has established that memory decays rapidly over the first 24 hours after an event, followed by a more gradual decline.)" The Facility had very limited mechanisms to prevent the potential contamination of testimonial evidence. The curriculum used by the Facility for training on abuse and neglect that all employees must complete did not include subject matter addressing this topic. The Facility's Abuse and Neglect policy did not address this topic. When an alleged perpetrator (AP) is placed on No Direct Contact (NDC) status he/she signs a letter acknowledging that they are not to contact co-workers during or after work hours; however, there does not appear to be any mechanism to attempt to monitor compliance with this requirement. In reviewing interview statements in DFPS case files investigators did not, with one exception (case 41285018), query the AP or collateral witnesses as to if they have been in communication with anyone regarding the incident under investigation. Conclusions in DFPS cases reviewed by the Monitoring Team, when video surveillance evidence is not available, were based almost entirely on testimonial evidence. If the integrity and efficacy of testimonial evidence can be questioned (both the truthfulness and the accuracy of recollection of events) then conclusions reached through the investigatory process can also be questioned. DSSLC, along with DFPS, need to establish a methodology that can reasonably protect testimonial evidence. Although the Monitoring Team raises this significant concern, based on criteria used in prior reviews of this and other facilities, it finds that safeguarding of physical evidence is adequate to result in a finding of substantial compliance with this provision.	
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision. The self-assessment process included a review of cases to determine if all incidents commenced within 24 hours. The Facility's self-assessment reported the following. The review of a random sample of	Noncompliance

	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.	20 cases from November, 2011 to February, 2012 indicated 18 of 20 cases (90%) commenced within 24 hours. Based on the findings from this self-assessment, the Facility determined that this Provision is not substantial compliance because the Facility is at 90% compliance. Note: the Facility's self-assessment was incomplete, as it did not address all required elements of the SA; for example, the Facility self-assessment only assessed compliance with one element of this Provision. <u>Monitoring Team Findings:</u> 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 reviewed the DFPS document intended to provide guidance to investigators as to what constitutes substantive investigatory activity that would confirm an investigation commenced within 24 hours of an incident being reported. DFPS guidelines did not require DFPS presence at the Facility within 24 hours of an incident being reported except in instances of Class 1 physical abuse and sexual abuse allegations. DFPS 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 physical evidence." These procedures do not address the protection of testimonial evidence from witnesses and any alleged perpetrators. Almost always testimonial evidence 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 potentially the need to isolate staff witnesses from one another in order to not 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 investigator training highlights the importance of timely interviewing noting "Interviews should be done as soon after the incident as possible, while witness' memories are still fresh. (Research has established that memory decays rapidly over the first 24 hours after an event, followed by a more gradual decline.)." 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>	

		DFPS had modified its report format to more clearly summarize investigatory activity undertaken by DFPS within 24 hours of an allegation being reported. Typical activity reported in case reports included telephone contact with the Facility's Incident Management Coordinator or Campus Coordinator to ensure the individual who is the subject of the report is safe (and if injured has received appropriate medical care) , that any known APs were placed in NDC status, the identification of any collateral witnesses, that the Facility has (or is) gathering all relevant documentation, that any physical evidence is secure, a determination if there is likely video surveillance evidence to review, and the development and review of a preliminary investigation plan. Six of eight (75%) cases in Sample D.1 documented these type of activities took place within the first 24 hours. Those that did not include case 41016516 and case 40452496. In case 41016516 (alleged physical abuse) the documented conversations between DFPS and the Facility did not reference either alleged perpetrator being placed in No Direct Contact status (NDC), or any other client protection measures. In case 40452496 (alleged physical abuse) the documented conversations between DFPS and the Facility did not reference any client protection measures taken, such as increased supervision. An additional measure to assess whether or not an investigation commenced within 24 hours of an incident being reported is to assess the date/time of the first substantive interview, which most typically would be of the reporter, a staff person, or an Individual who can share information that is believed to be reliable and relevant to the investigation. Only one (13%) of eight cases in Sample D.1 included interviews with collateral witnesses or the alleged perpetrator beginning within 24 hours of the report to DFPS. This was case 41158676. Onsite interviews of collateral witnesses' and APs often did not begin until four days after the report of an incident. For example, the first interview of an alleged perpetrator or collateral witness did not occur until: • Case 40452496 - 4 days after commencement of the investigation. • Case 40677457 - 4 days after commencement of the investigation. • Case 40881836 – 5 days after commencement of the investigation. • Case 41285018 - 4 days after commencement of the investigation. A significant time lapse between when an incident occurred and when alleged perpetrators and collateral witnesses are interviewed can potentially affect the integrity and efficacy of an investigation. This can occur because diminished memory recall or collaboration among witnesses can affect the integrity of testimonial evidence. There did not appear to be any effective mechanism to prevent the potential contamination of testimonial evidence. This is important because in DFPS cases reviewed by the Monitoring Team conclusions are based almost entirely on testimonial evidence. When the findings and conclusion of an investigation can be expected to rely primarily on testimonial evidence, it is critical that such evidence be gathered early in the investigation. The following summarizes the results of the review of DFPS Investigations (Note: two of	

		ten cases in the sample were administrative referrals and did not include a full investigation by a DFPS investigator): Two of eight (25%) investigations were not adequately commenced within 24 hours of the report of the incident. These were: 1. Case 40452496 was an allegation of physical abuse. The allegation included a report of a bruise to the ear and a slap mark on the cheek. The initial investigation activity conducted by DFPS did not document whether or not the investigator requested that a picture of the injuries be taken. The investigator did not appear onsite until two days after the allegation was reported. There was no documentation that the DFPS investigator and the Facility engaged in conversation regarding client protection measures being taken. 2. Case 41016516 was an allegation of physical abuse. The investigation report did not document preliminary investigatory activity such as that described in earlier paragraphs of this section. The only documented communication between the investigator and the Facility within the first 24 hours was "notified designee at DSSLC of the incident of possible physical abuse." This does not establish substantive investigatory activity. There was no documentation that the DFPS investigator and the Facility engaged in conversation regarding client protection measures being taken, including whether or not the two named alleged perpetrators were placed in NDC status. One of eight (13%) were not completed within 10 calendar days of the report of the incident. This was case 41285018. The documentation provided to the Monitoring Team included a DFPS Extension Request Form; however, it did not record the reason for the extension request nor did it include documentation that a supervisor had acted upon the request. Eight (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 presented in Provision D.3.f of this report. In one of the investigations reviewed, DFPS concerns and recommendations for corrective action were included and were appropriate to address issues identified by the DFPS investigator. Case 40881836 (unconfirmed neglect) did not include a concern as to the behavior of a staff person assigned 1:1 responsibility. This concern probably should have been noted as it materially affected the events that led to the allegation of neglect. <u>Facility Investigations (Sample D.2)</u> The following summarizes the results of the review of Facility investigations of serious	

		injuries: Four of four (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. Four of four (100%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. Four of four (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 presented in Provision D.3.f of this report. In all four of the investigations reviewed, recommendations for corrective action were included. In all four of the investigations (100%), the recommendations appeared adequate to address the findings of the investigation. The Monitoring Team has determined that the DSSLC was not substantial compliance with this component of the SA. To achieve compliance with this component of the SA substantive investigatory activity must begin with 24 hours of a report of an incident.	
	(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	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision. The self-assessment process included a review of cases to determine if all cases provided a clear basis for conclusion and that all cases properly identified all potential witnesses. The Facility's self-assessment reported the following. In a review of 20 cases (random sample) from November, 2011, to February, 2012 that 20 of 20 cases (100%) provided a clear basis for the conclusion and in each case all witnesses were identified. Based on the findings from this self-assessment, the Facility determined that this Provision is in substantial compliance because 100% of all cases provided a clear basis for the conclusion and 100% of all witnesses have been identified. Note: the Facility's self-assessment was incomplete, as it did not address all required elements of the SA; for example, validating that interview documentation included an accurate summary of questions posed. <u>Monitoring Team Findings:</u> The contents of the investigation reports reviewed were not always sufficient to provide a clear basis for its conclusion. Most reports utilized a standardized format that set forth	Noncompliance

	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.	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. 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 three of eight investigations reviewed (38%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. Those that were not included: • Case 41285018 – This was an allegation of abuse that resulted in an unconfirmed finding directed at the named AP and a confirmed finding directed at an unknown AP. The Facility staff person who apparently had the most direct knowledge of the incident was not interviewed. This was the hospital liaison nurse. The Facility UIR-113 that is part of this case file reports that during an Incident Management Team meeting the Facility nurse serving as the Hospital Liaison informed the team that while doing rounds at Denton Regional Medical Center (DMRC) on February 8, 2012**,** she was approached by a DMRC nurse that was upset with the sitter that was providing 1:1 supervision on Tuesday, February 7, 2012 on the 10:00pm to 6:00am shift**.** The DRMC nurse stated that the staff member with a thick accent that was providing 1:1 supervision was telling him to get back in his room, stay in bed, and he physically restrained him to keep him in bed. The Facility Unit Director identified this staff member and indicated he would be reassigned to the Campus Coordinators office upon his return to work. The DFPS investigation for some reason focused on the Individual's care at the hospital on 2/8, 2pm to 10pm shift. The investigation did	

		not include an interview with the Facility's hospital liaison nurse. The first substantive interview with a person expected to have knowledge of the alleged incident did not occur until 2/14/12. The Facility review of the DFPS report did not identify this inconsistency. The DFPS disposition of the case was unconfirmed emotional/verbal abuse and unconfirmed physical abuse with the named AP, primarily because time/attendance records did not place him at the hospital with a sitter assignment on 2/8 for the 2-10 shift. It also had a disposition of confirmed abuse with an unknown perpetrator because of testimony from a hospital nurse who worked on 2/8 on a shift that overlapped with the Facility 2-10 shift. It is unclear if this alleged incident occurred on 2/7 or 2/8. The investigation should have probed deeper, including re-interviews with some principle witnesses, including the hospital nurse who made the initial allegation. • Case 40677457 – this was an allegation of physical abuse with an inconclusive finding. The investigation report did not report that video evidence was reviewed even though it may have provided insight as to staff or peers going into the alleged victim's bedroom. The report also indicated that the investigator accepted as fact that a particular staff person worked two consecutive shifts as a 1:1. It is unlikely that a staff person would be assigned 16 hours of 1:1 without relief. The report narrative does not address this. Finally, all staff interviews occurred four days after the report of the incident. The interview with the AP included the statement "she (AP) attempted to perform a basket weave release." This statement suggests the staff person may have been engaging the Individual in restraint but this is not articulated as a concern in the Concerns and Recommendations section of the report. • Case 40861876 - this was an allegation of physical abuse with an inconclusive finding. This allegation was also investigated by OIG who returned a finding of substantiated criminal activity. The DFPS investigation did not appear to probe in sufficient depth to determine the cause of the injury to the alleged victim. If the cause of the injuries was most likely the result of trauma, and there was insufficient evidence to determine who inflicted the trauma (and that it wasn't self-inflicted) then it would appear that a finding of confirmed physical abuse perpetrator unknown may have been more appropriate. In fact, DFPS did change the finding to confirmed after doing an OIG comparison review and collecting additional evidence. • Case 41016516 - this was an allegation of physical abuse with an unconfirmed finding. There are several dates noted in the report that appeared to be in conflict. For example, the date of the initial face-to-face interview is noted as 1/4/12 in one section of the report and 1/5/12 in another. Additionally, the report notes that DFPS did not review the video evidence but relied on the Facility camera monitor's account of what the tape showed. If DFPS is going to accept indirect evidence (someone else's account of what is on video	

		surveillance tape) at a minimum this information should come from a trained Facility investigator. The report utilized a standardized format that set forth explicitly and separately • In eight (100%), each serious incident or allegations of wrongdoing; • In eight (100%), the name(s) of all witnesses; • In eight (100%), the name(s) of all alleged victims and perpetrators; • In eight (100%), the names of all persons interviewed during the investigation; • In eight (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; • In eight (100%), all documents reviewed during the investigation; • In eight (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; • In eight (100%), the investigator's findings; and • In eight (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 two of four investigations reviewed (50%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. Those that were not were UIR 086 and UIR 095. UIR 086 included reference of video review showing the Individual entering his bedroom without an injury and coming out of the bedroom with an injury. The report did not indicate if the video review noted any staff or peers going in to or out of the bedroom. UIR 095 reported a nurse's opinion that the Individual's fractured leg was not the result of involvement with the bedrail because the type of fracture was not the result of twisting. The validity of this hypothesis should have been reviewed with at least a Facility physician and preferably an orthopedic specialist. • The report utilized a standardized format that set forth explicitly and separately o In four (100%), each serious incident or allegations of wrongdoing. o In none (0%), the name(s) of all witnesses. The UIR records the names of staff and their involvement (e.g. on duty or a witness) at the location or suspected location of the incident. This does not necessarily include all witnesses, for example, another individual or a visiting family member could be a potential witness. o In four (100%), the name(s) of all alleged victims and perpetrators. o In four (100%), the names of all persons interviewed during the investigation. 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. The Monitoring Team would expect a Facility investigation report to document, with specificity, interviews that occur, for example "staff John Doe was interviewed by investigator Jane Doe on xx/xx/xx and reported the following:….." o In four (100%), all documents reviewed during the investigation; o In four (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 four (100%), the investigator's findings; and o In four (100%), the investigator's reasons for his/her conclusions. The Monitoring Team has determined that the DSSLC was not substantial compliance with this component of the SA because not all investigations contain sufficient evidence to have a clear basis to draw a conclusion, or have sufficient evidence but appear to draw an inappropriate conclusion.	
	(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.	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision. The self-assessment process included a review of cases to see if review by supervisor was completed and if needed corrections were made. The Facility's self-assessment reported the following. The review of cases from November, 2011 to February, 2012 (random sample) indicated that 20 of 20 cases (100%) were reviewed by the supervisor to ensure cases are complete and accurate. Based on the findings from this self-assessment, the Facility determined that this Provision is in substantial compliance because adequate supervisory review is occurring for all cases Note: the Facility's self-assessment was incomplete as it did not address all required elements of the SA, for example no methodological information was provided to explain how determinations of accuracy, completeness, and coherency were determined. This is especially important given the issues identified in Provision D.3.f by the Monitoring Team. <u>Monitoring Team Findings:</u> Facility 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.	Noncompliance

		To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Sample D.2) were reviewed. The results of these reviews are discussed below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: Eight of eight (100%) case files reviewed contained evidence that the DFPS supervisor had conducted a review of the investigation report. In five of eight (63%) concerns were identified by the Monitoring Team (refer to Provision D.3.f) that should have been detected through the DFPS supervisory review. In all eight (100%) case files, there was evidence that the DSSLC Incident Manager Coordinator had conducted a review of the investigation report. In five of eight (63%) concerns were identified by the Monitoring Team (refer to Provision D.3.f) that should have been detected by the IMC review and reported back to DFPS to correct deficiencies or complete further inquiry and were not. 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 and several other executive level staff. The purpose of this group is to review 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. In five of eight (63%) investigations concerns were identified by the Monitoring Team (refer to Provision D.3.f) that should have been identified by the Review Authority and were not. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: • In all four investigation files reviewed there was evidence that the supervisor of investigations had conducted a review of the investigation report. • In two of four (50%), 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 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.	Facility Self-Assessment: The Facility engaged in the following activities in conducting its self-assessment of this Provision. The self-assessment process included a review of cases to determine that each case had a written report per the provisions of "subparagraph g." The Facility's self-assessment reported the following. The review of 20 cases (random sample) from November, 2011 to February, 2012 reflects 20 of 20 cases (100%) had a written report. Based on the findings from this self-assessment, the Facility determined that this Provision remained in substantial compliance because all cases contained a written report. Note: the Facility's self-assessment was incomplete, as it did not address all required elements of the SA; for example, for the written report to be subject to the provisions of subparagraph g it must adequately identify the type of issues identified in subparagraph g. This was not assessed by the Facility. Monitor Team Findings: The Monitoring Team identified three separate review forms used in documenting investigation review in case files. These were: 1. DSSLC Incident Management Team Review of DFPS Investigations. This form documents review of each DFPS investigation report by the Facility's Review Authority described in policy. 2. DSSLC Incident Management Team Review of DFPS Investigations. The IMRT also reviews each DFPS case report. 3. Investigation Review/Approval Form. This form is used by the IMC to validate incident management supervisory review of UIRs. The information contained in these forms served to document the occurrence of these reviews. The reports that result from this review activity are to document that the investigation was thorough and complete and that the report was accurate, complete and coherent. In instances where this was not the case these reports should document actions taken by the Facility to correct deficiencies. As reported in Provision D.3.f the Monitoring Team identified substantive issues with five of eight (63%) DFPS investigation reports sampled. As reported in Provision D.3.g Facility review activity did not identify any of these issues in any of these cases. The written reports provided to the Monitoring Team were insufficient to demonstrate compliance with this Provision. The Facility had received a compliance rating of	Noncompliance

		substantial compliance in the last review based on the presence of reports. The Monitoring Team does not believe the presence of a report, by itself, is sufficient to achieve compliance with the SA requirements associated with this Provision. Reports produced pursuant to this provision must document issues identified by Facility reviewers and what was done to address those issues (refer to Provision D.3.g).	
	(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.	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision. The self-assessment process included a review of the Incident Management Tracking (IRMT) Log to ensure that disciplinary and programmatic actions were documented and a review of Campus Administrator's (CA) walk-throughs to ensure that recommendations have been tracked and the actions of the corresponding outcomes have been documented. The Facility's self-assessment reported the following. The review of the IRMT tracking log from November, 2011 to February, 2012 showed all recommendations from all incidents are documented in the log. The review of the walk-throughs completed by the CA from November, 2011 to February, 2012 showed all recommendations have been tracked and the actions of the corresponding outcomes have been documented. Based on the findings from this self-assessment, the Facility determined that this Provision was in substantial compliance because all disciplinary or programmatic actions are tracked and documented with corresponding outcomes. Note: the Facility's self-assessment was incomplete as it did not address all required elements of the SA; for example, the outcomes of corrective actions intended to assess recurrence of similar events was not assessed. <u>Monitoring Team Findings:</u> 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 on late reporting. Documentation	Noncompliance

		would validate that the training occurred; however, there did not appear to be any work effort directed at validating that the training prevented recurrence. For example, had the frequency of late reporting decreased? Case files reviewed by the Monitoring Team included copies of all relevant disciplinary action taken in response to investigation findings. The systems in place at the Facility to achieve compliance with this Provision were deficient in meeting an important element of this component of the SA: assessing if the outcomes of disciplinary or programmatic actions corrected a situation and/or prevented recurrence. For example, staff training was often a recommendation from IMRT reviews. The Monitoring Team was unable to determine if the Facility engaged in any administrative review activity to determine if training and retraining (related to specific subject matters) had resulted in a change (decrease or increase) in the problem(s) the training directed by the IMRT was intended to address. The Monitoring Team has determined that the DSSLC was not in substantial compliance with this component of the SA. The Facility had received a compliance rating of substantial compliance in the last review because administrative and programmatic action had been taken and was documented. The Monitoring Team believes in order to achieve substantial compliance additional effort is required to track and document these actions and the corresponding outcomes with respect to their collective impact in preventing reoccurrence of the same, or similar, problems.	
	(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.	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision. The self-assessment process included an evaluation of current records area for easy accessibility. The Facility's self-assessment reported the following. After evaluation of the record area it was concluded that the current area/system is efficient and meets the requirements. Based on the findings from this self-assessment, the Facility determined that this Provision remains in substantial compliance because the system allows investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual. <u>Monitor Team Findings:</u> 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.	Substantial Compliance

		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 determined that the DSSLC was in substantial compliance with this component of the SA.	
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.	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision. The self-assessment process included a review of the revised Trend Report to ensure that all unusual incidents are tracked by incident, staff alleged, individuals involved, location, date and time of incident and causes outcomes of incidents. The Facility's self-assessment reported the following. Trend reports from November, 2011 to February, 2012 reflected the above data changes. Based on the findings from this self-assessment, the Facility determined that this Provision is in substantial compliance because trends reports now include longitudinal data. <u>Monitoring Team Findings:</u> 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. Since the last review the Facility had made improvements in its Trend Report, most notably in tracking data longitudinally. An area still in need of improvement is tracking data on the results and outcomes of incidents and investigations, by type (e.g. Physical abuse Class I, Class II, Neglect, etc.), including data that can tell the Facility, for example, if the frequency of confirmed and/or inconclusive findings is increasing or decreasing. For example, (hypothetically) if data comparing six-month periods showed that confirmed finding of physical abuse increased from 2% of allegations made to 4% of allegations made one would expect executive level discussion looking more in-depth at the confirmed investigation reports. Similarly, significant changes in the percentage of cases with inconclusive findings should cause more in-depth review and analysis. Trend data should be presented in a manner that lends itself to useful discussion and decision-making. To achieve compliance with this Provision the Facility needs to track the results of investigations of incidents and allegations present data in a manner that lends itself to useful discussion and decision-making.	Noncompliance

D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision. The self-assessment process included a review of Due Diligence checklists from Job Requisition Coordinators to ensure that all staff, volunteers had background checks of both ANE and criminal history and were cleared before working with individuals served. The Facility's self-assessment reported the following. Reviewed 16 checklists (random sample) from November, 2011 to February, 2012, Sixteen of 16 (100%) staff had due diligence checks completed before they worked directly with the individuals. Based on the findings from this self-assessment, the Facility determined that this Provision remained in substantial compliance because 100% of staff had due diligence checks completed and cleared before they worked directly with the individuals. <u>Monitoring Team Findings:</u> By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks. In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 25 employees and nine 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, 2011. Once the fingerprints were entered into the system, the Facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. 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	Substantial Compliance

		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.1, D.2.a, D.2.i, D.3.a, D.3.e, D.3.f, D.3.g, D.3.h, D.3.i, and D.4).
2. Ensure Facility investigations of serious incidents include all components necessary to demonstrate compliance with SectionD.3.f of the SA (Provision D.3.f).
3. Improve the effectiveness of Facility review of investigation (Provision D.3.g and D.3.h)
4. Improve the effectiveness of Facility investigations on non-serious discovered injuries to rule out abuse and neglect (Provision D.1)
5. 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).
6. Establish a method that can reasonably protect testimonial evidence (Provision D.3.f).

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 Self-Assessment 3/16/12 2. DSSLC Action Plan 3/8/12 3. DSSLC Section E Presentation Book 4. DADS Policy 003.1 - Quality Assurance 1/26/12 5. DSSLC Policy CMGMT-15 Quality Enhancement Process, dated 1/5/10 6. DSSLC QA Plan 3/2/12 7. DSSLC Policy C&C-02 Quality Assurance/Quality Improvement Council 9/6/11 8. Quality Assurance/Quality Improvement Council Meeting: Data Analysis Report October, 2011 through March, 2012 9. Quality Assurance/Quality Improvement Council meeting minutes October, 2011 through March, 2012 10. Monitoring tools and guidelines for each provision of the SA (various dates) 11. Allegations Trend Report 2/12 12. Unusual Incidents Trend Report 2/12 13. Restraint Trend Report 2/12 14. Injury Trend Report 2/12 **People Interviewed:** 1. Lori Powell, Director of Quality Assurance **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 4/2/12 2. Restraint Reduction Committee 4/4/12 3. Quality Assurance/Quality Improvement Council (QA/QI Council) meeting 4/3/12
	Facility Self-Assessment: The Facility self-assessment reported substantial compliance with Provision E.3. The Monitoring Team was unable to confirm substantial compliance. The self-assessment process focused primarily on a set of activities to review longitudinal data reports, Quality Assurance/Quality Improvement (QA/QI) Council meeting minutes, review of the QA Plan to determine that it accurately reflected ongoing monitoring, and review of Quality Indicators to determine that monthly data is collected as required for QA/QI meetings. The Facility self-assessment accurately reported several key areas of deficiency, for example, unreliable data reported from some monitoring tools. The Facility's Action Plan that accompanies the self-assessment included steps to improve processes that would lead to compliance with the Settlement Agreement. Additional action steps will need to be developed to address issues identified by the Monitoring Team which are not sufficiently addressed in the current Facility Action Plan.
	Summary of Monitor's Assessment: The work effort observed during this monitoring visit demonstrated continued improvement in the development and implementation of an effective QA system.

	The DSSLC had a Quality Assurance/Quality Improvement Council in place that meets twice a month. The work of the QA/QI Council is organized so each Provision of the SA is reviewed at least quarterly. The Monitoring Team commends the Facility for revising trend data to include longitudinal data. There are still additional revisions to longitudinal tracking that should be considered. For example, the Allegations Trend Report reports the day of the week, shift, and hour of the day for allegations for the report month It may be useful to track these data over an extended period of time as it could have implications for staffing, supervision, and activity levels of individuals. The Facility had also identified a set of key indicators it believes it should use to track organizational performance. Data affecting 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, non-serious injuries, abuse/neglect/exploitation confirmations, medication errors, oral hygiene, environmental conditions, community referrals, and community placements. These were good metrics from which organizational performance (and SA compliance) can be measured. The Facility is to be commended for incorporating key indicator data in its QA process. It did not appear the process for inter-rater reliability had made much progress since the last review. For example, in reviewing the most recent QA report prepared for the QA/QI Council (February, 2012) none of the 197 data tables and graphs presented in the monthly report included inter-rater reliability data. In the last review it was noted the DSSLC did not have an organized and operational system for the development, implementation, and tracking of corrective action plans (CAPs). Since the last review the Facility had put a system in place to do this. This system is supported with a database. Implementation was limited. The Facility was unable to describe any process to determine if a CAP was effective in remedying or reducing the problems originally identified. There was no 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. The Facility QA process did not appear to be using available data to identify individuals with concerns across multiple areas (e.g., injuries, incidents, hospitalizations or ER visits, restraints, etc.), and use these data to identify possible systemic issues. The Facility had established workgroups for each Provision of the SA. The workgroups were to develop

	operational plans to achieve SA compliance in their respective areas. They were also to develop a QA component for their respective Provision. The Monitoring Team did not probe the implementation status of these work activities but will do so at the next review. The Facility's self-assessment did not address the status of these work activities and should prior to the next review. Provisions of the SA should have a QA component managed by administrative staff responsible for that Provision that feeds in to the overall Facility QA program coordinated and managed by the QA Department. DADS had issued a new policy on Quality Assurance on 1/26/12. The DSSLC needs to revise its Facility specific QA policies to reflect any DADS requirements which are not already in Facility policy.

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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.	Facility Self-Assessment: The Facility engaged in the following activities in conducting its self-assessment of this Provision: • Reviewed longitudinal data reports. • Reviewed the Quality Assurance/Quality Improvement (QAQI) Council meeting minutes to determine if the Council meets at least monthly. • Reviewed QAQI Council meeting minutes to determine if the Council is reviewing the incident management data quarterly. • Reviewed the QAQI Council meeting minutes to determine if the Council is reviewing the restraint data quarterly. • Reviewed the QAQI Council meeting minutes to determine if the Council is reviewing the POI section monitoring quarterly. • Reviewed the QAQI Council meeting minutes to determine if corrective actions are needed and/or identified. • Review of the QA Plan to determine that it accurately reflects ongoing monitoring. • Reviewed Quality Indicators to determine that monthly data is collected requirement for meetings to be held at least monthly The Facility's self-assessment reported the following: • The longitudinal data has been expanded. • Since the last compliance visit the QAQI Council met twice in October, November, December, January, and February, thus meeting the requirement for meetings to be held at least monthly. • The QAQI Council meeting minutes indicate the Council is reviewing the incident management data quarterly. • The QAQI Council meeting minutes indicate the Council is reviewing the restraint data quarterly. • Since the last compliance visit the QAQI Council reviewed the following POI	Noncompliance

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		monitoring: 10/18/11 – Sections G, H, I, J, L, M, O, P, Q 11/15/11 – Sections F, M, R, S, T, U, V 12/20/11 – Sections C, D, E, K, M, N 1/17/12 – Sections G, H, I, J, L, M, O, P, Q 2/21/12 - Sections F, M, R, S, T, U, V The current schedule for quarterly review is being followed to ensure all sections are reviewed quarterly. • Since the September court monitor visit the QAQI Council has reviewed corrective action plans submitted at the time of the QAQI Council meeting. Since the September court monitor visit the QAQI Council reviewed the Quality Assurance Plan at two of five meetings as it was updated to reflect the recent revision to monitoring as agreed by QA and the department. • The Quality Assurance Plan is comprehensive and contains all required elements. • Since the development of the Key/Quality Indicators the QAQI Council reviewed them for accuracy and/or revisions in five of five meetings. Based on the findings from this self-assessment, the Facility determined that this provision was not in substantial compliance because the expanded format has had insufficient time to track data longitudinally across the various departments timely and share with the QAQI Council quarterly. <u>Monitoring Team Findings:</u> The Monitoring Team commends the Facility for revising trend data to include longitudinal data. There are still additional revisions to longitudinal tracking that should be considered. For example, the Allegations Trend Report reports the day of the week, shift, and hour of the day for allegations for the report month. It may be useful to track these data over an extended period of time as it could have implications for staffing, supervision, and activity levels of individuals. For example, if allegations are disproportionally represented on certain days of the week, certain shifts, or in clearly delineated time windows, it's conceivable that activity schedules, staffing ratios, or supervisory presence may need to be examined. At a minimum these data, when reviewed longitudinally, can give clues as to administrative and programmatic processes that may contribute to outcomes, positively or negatively. The Facility had established workgroups for each Provision of the SA. The workgroups were to develop operational plans to achieve SA compliance in their respective areas. They were also to develop a QA component for their respective Provision. The Monitoring Team did not probe the implementation status of these work activities but	

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		will do so at the next review. The Facility's self-assessment did not address the status of these work activities and should prior to the next review. Most Provisions of the SA should have a QA component managed by administrative staff responsible for that Provision that feeds in to the overall Facility QA program coordinated and managed by the QA Department. The DSSLC had a Quality Assurance/Quality Improvement Council in place. It was reported this group met twice a month. One meeting was a formal meeting to review data, discuss trends, and identify the need for action plans. The second meeting of the month was focused more comprehensively on one subject. For example, the meeting held during the week of the review focused on various wellness initiatives in the process of implementation. This included discussion of exercise opportunities and food service product offerings that would provide healthy alternatives to some products currently in use. The Monitoring Team reviewed the minutes and report packages used for each of the monthly primary QA/QI Council meetings held since the last review. This review confirmed the following: A report is prepared for presentation at the meeting that includes quantitative monitoring data on several provisions of the SA. These reports were generated from Monitoring Tool data. The work of the QA/QI Council is organized so each provision of the SA is reviewed at least quarterly. The Facility had also identified a set of key indicators it believes it should use to track organizational performance. Data affecting 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 good metrics from which organizational performance (and SA compliance) can be measured. The Facility is to be commended for including key indicator data in its QA process. In the last review, the Facility reported it had begun a more formal process for inter-rater reliability from that observed previously. Most monitoring tools are administered by unit/department staff and by QA staff. As a result a process for inter-rater reliability can occur. It did not appear this process for inter-rater reliability had made much progress. For example, in reviewing the most recent QA report prepared for the QA/QI Council (February, 2012) none of the 197 data tables and graphs presented in the monthly report included inter-rater reliability data. As noted in previous reports, the Monitoring Team believes a Quality Assurance (QA) and Corrective Action Planning (CAP)process should include two sets of activities and strategies for outcomes:	

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		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. In its last report the Monitor Team noted that QA activity at DSSLC consisted largely of work effort directed at the first of these two strategies. This continued to be the case. 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 needing attention, and, to determine if previously completed CAP activity has met the desired outcome of remedying or reducing the problems originally identified. 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. As referenced above, the monthly report prepared for the February QA/QI Council included 197 data tables and graphs. These were directed at Provisions C, D, F, I, J, K, M, N, O, P, Q, R, S, T, U, and V of the Settlement Agreement. Finally, DADS had issued a new policy on Quality Assurance on 1/26/12. The DSSLC needs to revise its Facility specific QA policies to reflect any DADS requirements which are not already in Facility policy.	
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	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision. • Reviewed Quality Assurance plan and discussed needed revisions. • Reviewed corrective action plan tracking log. • Reviewed tracking and trending of data presented in the QAQI reports for	Noncompliance

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	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.	October 2011, November 2011, December 2011, January 2012, and February 2012. • Reviewed inter-rater reliability data. • Reviewed QAQI minutes for October 2011, • November 2011, December 2011, January 2012, and February 2012. • Reviewed data analysis by Section Leads. The Facility's self-assessment reported the following. • QA Plan is being revised to include a data library. • Of the 20 formal corrective action plans implemented and reflected on the CAP tracking log, timely identification of completion was lacking, and evidence of completion not provided timely. • The monitoring tool data for some sections does not appear to be reliable, especially for those sections achieving 100% when the Facility has identified those as focus areas for improvement. • Inter-rater reliability data has not been presented to QAQI as of yet and is insufficient due to all sections not having an inter-reliability check at this time. • The QAQI minutes include what sections were discussed, corrective action plans submitted, and any required follow up action. • On 2/21/12 the QAQI Council recommended that data will be given to the Section Leads a couple weeks before the QAQI meeting. Section Leads will then analyze their data and send the analysis back to the Data Analysts prior to the meeting to include in the report. Based on the findings from this self-assessment, the Facility determined that this provision was not in substantial compliance because data was not consistently reliable in all sections to drive systemic changes, and the Facility is in the beginning stages of collecting reliable analysis of the data from the Section Leads. The Facility is in the beginning stages of the follow-up of Corrective Action Plans to ensure there is evidence of completion. <u>Monitoring Team Findings:</u> Monitoring Team review of documents validated the important findings of the Facility self-assessment, including: • For Corrective Action Plans implemented and reflected on the Facility CAP tracking log, timely identification of completion was lacking, and evidence of completion was not provided timely. • The monitoring tool data for some sections did not appear to be reliable, especially for those sections achieving 100% compliance when the Facility had identified those as focus areas for improvement.	

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		• Inter-rater reliability data had not been presented to the QA/QI Council and inter-rater reliability data was insufficient due to inconsistent implementation. In the last review it was noted the DSSLC did not have an organized and operational system for the development, implementation, and tracking of corrective action plans. Since the last review the Facility had put a system in place to do this. This system is supported with a database. Implementation was limited. The system had generated a small number of CAPs, most in the area of restraint implementation. CAPs were overly specific. For example, a separate CAP was generated for each and every documentation error on a Restraint Checklist, or each and every error a QA auditor made in assessing restraint documentation. Ordinarily, CAPs should address a problem, such as, "Restraint Checklists are not always completed correctly," followed by a brief description of planned actions to be taken (and by whom and within what timeframe) that would be intended to correct the problem. Or, "QA Auditors are inconsistent in their interpretation of restraint policy when assessing restraint documentation," followed by a brief description of planned actions to be taken (and by whom and within what timeframe) that would be intended to correct the problem. This approach would also lend itself to an evaluation that the CAP remedied and/or prevented the recurrence of problems. In the above example, it should be possible to evaluate whether the action steps in a CAP achieved the anticipated outcome, i.e. a reduction in restraint documentation errors, or improved accuracy in restraint reviews conducted by QA auditors. Most of the data reviewed by the QA/QI Council comes from the monitoring tools that are used for each provision of the SA. As noted above there was 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 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. The Facility reported it had begun a process to achieve this. The Monitoring Team looks forward to progress in this regard at the next review. 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	

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		that require improvement, as well as to identify an array of potential systemic issues requiring attention. Please refer to Provision E.1 for additional information that effects compliance with this Provision. Finally, the Facility QA process did not appear to be using available data to identify individuals with concerns across multiple areas (e.g., injuries, incidents, hospitalizations or ER visits, restraints, etc.), and use these data to identify possible systemic issues. To the extent such review takes place it appropriately occurs through the IDT and risk assessment process; however, in order to facilitate organizational performance improvement such data needs to be reviewed and analyzed from a facility-wide perspective. The work effort observed during this monitoring visit demonstrated continued improvement in the development and implementation of an effective QA system.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision. • Established Corrective Action Plan (CAP) database. • Reviewed Quality Assistance System Flow Sheet. • Reviewed requirements for corrective action plans. • Conducted observations at QA/QI for dissemination of corrective action plans. The Facility's self-assessment reported the following. • CAP database included a date of when the CAP was disseminated to responsible parties. • The review of the Quality Assistance System Flow Sheet found that the Quality Assurance Department coordinates quality assurance activities with multiple departments. • Corrective action plans are required when compliance data drops below the identified threshold of 80% and there has not been any improvement for 2 months. • Observations during QAQI found that completed Corrective Action Plans are all disseminated during the meetings. Additionally, a Corrective Action Plan is requested at any time at the discretion of the QA/QI Council. Based on the findings from this self-assessment, the Facility determined that this provision is in substantial compliance because data reviewed could verify that all entities	Noncompliance

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		responsible received the corrective action plans for implementation Monitoring Team Findings: As explained to the Monitoring Team, the Facility relied on review of its CAP Tracking System to validate that corrective action plans were disseminated to all entities responsible for their implementation. There are several data entry boxes on the tracking sheet that could serve to accomplish this. One is "Assigned To." Some CAPS reviewed had a name in this box but others had the name of a Department, for example, Quality Assurance. Another data box is "Follow-up Monitor." This box was almost always blank. From its title it could be assumed the name appearing in this box would have something to do with implementation responsibility. Finally, there is a data box labeled "Dissemination." This box was either empty or contained a date. Data in the CAP Tracking Log was insufficiently organized to provide the Monitoring Team with assurance that CAPs were disseminated to all parties responsible for their implementation.	
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.	Facility Self-Assessment: The Facility engaged in the following activities in conducting its self-assessment of this Provision. • Reviewed follow up needed on corrective action plan database. • Conducted observations at QA/QI for Corrective Action Plan implementation. • Reviewed requirements for corrective action plans. • Interviewed section leaders on knowledge of corrective action plans. The Facility's self-assessment reported the following. • The corrective action plan database listed areas where follow up was needed but did not provide information on whether or not the desired outcome was met. Corrective action plan tracking tool does not include all plans requiring corrective action based upon the requirements provided to the section leaders. Not all evidence for corrective action plans has been received by the QAD. • Observations during QA/QI found that completed Corrective Action Plans are disseminated and the implementation of the plans is discussed during the meetings. • Corrective action plans are required when compliance data drops below the identified threshold of 80% and there has not been any improvement for 2 months. • Not all section leaders interviewed could state how they tracked whether or not a corrective action plan has met the desired outcome. Based on the findings from this self-assessment, the Facility determined that this provision is not in substantial compliance because the corrective action plan data base	Noncompliance

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		could not identify whether or not a previously completed corrective action plan has met the desired outcome. Monitoring Team Findings: 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 other delineations such as the Department assigned responsibility for implementation. At the time of this review, organization of CAP tracking data of this nature could not be done. As noted in Provision E.2, the Facility was unable to describe any process to determine if a CAP was effective in remedying or reducing the problems originally identified. To achieve compliance, the Facility must maintain the improvements made, ensure most CAPs are completed within assigned timeframes or that there is documentation of status reports, and gather and report information (including data when appropriate) to evaluate whether the CAP (or a set of related CAPs) was effective in remedying or reducing the problems originally identified and is revised if not effective.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	Facility Self-Assessment: The Facility engaged in the following activities in conducting its self-assessment of this Provision. • Reviewed follow up needed on corrective action plan data base. • Reviewed evidence submitted for corrective action plans to ensure the implementation of the corrective action plans and to review for effectiveness. The Facility's self-assessment reported the following. • The corrective action plan database provided information when follow up was needed. • Observations during QA/QI indicated not all members are familiar with the process of modifying corrective action plans. • Evidence was not submitted to the Quality Assurance Director if corrective action plans were modified. Based on the findings from this self-assessment, the Facility determined that this provision was not in substantial compliance because staff responsible for monitoring the effectiveness of corrective action plans could not consistently state their monitoring process and identify when revisions are necessary. Monitoring Team Findings:	Noncompliance

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		As described in Provision E.2, the Facility did not appear to have a method to determine the effectiveness of a CAP, only that the steps in a CAP had, or had not, been carried out, and the timeliness in which they had been carried out. Without an evaluative methodology to determine the effectiveness of a CAP it is unlikely a determination could be made that a CAP requires modification. To achieve compliance with this provision, the Facility 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. Develop a system of "weighting" data items on monitoring tools, where appropriate (Provision E.1).
2. 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).
3. Develop a methodology to define and identify staff who should and do receive CAPs (Provision E.3).
4. Organize information related to CAPs in such a way data can be used to help identify systemic issues (Provision E.2).
5. 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. Denton State Supported Living Center (DSSLC) Self-Assessment, updated 3/16/2012 2. Denton State Supported Living Center Action Plans, updated 3/18/2012 3. Denton State Supported Living Center Report for Monitors, dated April 2, 2012 4. Section F Presentation Book materials 1. DADS Policy 004 Personal Support Plan Instructions, dated 7/30/10 2. DSSLC Policy CMGT-12.01 Personal Support Planning Process, dated 1/3/11 3. DSSLC Policy CMGT-12.01 Personal Support Planning Process Pilot Project Personal Focus Assessment and Facilitation, dated 8/5/11 5. Annual Assessments Filed 10 Days Prior to PST by Assessment, dated 2/1/2012-2/29/2012 and 3/1/2102-3/31/2012 6. 30-Day ISPs, Assessments and SAP/Quarterly Reviews for Individuals #355, #476, and #679 7. ISP Assessments for Individuals #1, #35, #37, #118, #548, #554, #686, #758, #763, and #769 8. Sample of recent Individual Support Plans/Personal Support Plans (ISPs/PSPs) and Personal Focus Assessment (PFA) for Individuals #122, #235, #336, #511, #537, #588, and #742 9. Quarterly Reviews for Individuals ##122, #151, #235, #336, #511, #537, #588, #679, and #742 10. QA/QI Council Meeting: Data Analysis Report, Sections F. R, S, T, U, V and M, dated February 21, 2012 **People Interviewed:** 1. Andy Maher, Director of Community and Family Relations (CFR) 2. Frank Padia, QDDP Coordinator 3. Lori Powell, Director of Quality Assurance 4. Linda Ford, Director of Active Treatment **Meeting Attended/Observations:** 1. ISPs for three Individuals: Individuals #1, #53, and #464 2. Personal Focus Assessment/Interview (PFI) meeting for Individuals #381 and #53
	Facility Self-Assessment: The Monitoring Team reviewed the DSSLC Self-Assessment and Action Steps. 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 concurs. The current Self-Assessment reported on the activities engaged in to conduct the self-assessment, provided its evaluation of the results of the self-assessment and finally provided a self-rating stating why or why not it believed compliance had been achieved. The Facility had begun in some instances to attempt to couple the self-assessment with its internal quality assurance processes to assess ongoing progress toward completion and the actual outcomes, in that it reviewed the results of internal Section F Monitoring Tools as a primary part of it self-assessment processes. However, these data were based on very limited samples thus far and the Facility noted concerns with inter-rater reliability, so it was not yet likely this information provided a sound basis for evaluation. In the Action Plans, dated

	03/08/2012, the Facility indicated one such step was to develop an overall QA plan involving monitoring tools, QDDP audit tools, active treatment tools and any other applicable tools. This action was noted to be in progress with a projected completion date of 06/01/2012. The Monitoring Team recommends this be considered a priority towards compliance with this Section.
	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. Overall, the Facility's progress had not been substantial in developing and implementing 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, although some improvements were identified. A summary of progress noted included some improvements in assessment processes across various disciplines; while this was not universal, nor was it always substantial, it was indicative of a positive direction. Staff attendance at ISP meetings showed considerable improvement, and the ISP was typically found to be accessible to Direct Care Staff (DCPs). Direction and training had been provided to IDT members regarding their responsibilities to include in their assessments specific recommendations as to the most integrated setting for individuals and there were signs staff were beginning to implement this requirement. Finally, it was noted the Facility continued to provide a relatively high level of community outing opportunities and sought to develop additional opportunities such as its recently-opened off-site retail outlet, Impressions, where crafts and artwork created by individuals living at the Facility would be sold to the general public. Plans called for Impressions to be used as a training site where individuals would create items to be sold as well as practice skills beneficial for transitioning to community living, such as retail sales skills, socialization, and money management. In addition to the progress noted, specific findings as to each provision are as follows: **Provision F1:** The Facility continued to implement the "Supporting Visions" ISP process, which was intended to reinforce the concept that planning is intended to support the individuals' vision for the future. A somewhat revised ISP format and process had been recently introduced. This ISP process was still meeting with limited success specific to the requirements of this section of the SA. There was still no meaningful preparation provided to ensure the PFI and/or ISP processes were conducted in a manner that facilitated real participation by the individuals. The Facility continued to devote considerable resources to training, monitoring, and coaching for QDDPs, an effort the Monitoring Team commends. As of yet, however, only four QDDPs had been certified as competent in ISP facilitation skills, and the Monitoring Team could not always validate competency for these staff. The Facility should redouble its efforts to develop competency among the QDDPs, both the currently certified and those yet to be deemed competent. As noted in its Self-Assessment, DSSLC had undertaken some initiatives to improve the timeliness and strengthen the quality of its assessment practices. These had met with limited success thus far. IDTs often

	failed to conduct comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs. The Monitoring Team found this remained a pervasive issue at the Facility that will need 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, ISPs lacked many of the criteria specified in the SA for this Provision. ISPs still 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. The Monitoring Team also found ISP strategies did not reflect encouragement of community participation in any meaningful or purposeful manner.

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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 members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	The Qualified Developmental Disabilities Professional (QDDP) was the one person assigned to each individual to facilitate the work of each IDT. The Facility reported that it had 28 QDDPs and a QDDP Coordinator. Approximately five or six were newly hired as reported by the Facility. The Facility reported only four QDDPs were deemed competent to facilitate ISP meetings, these being the same four who were deemed competent during the previous compliance visit. As was the case in the last monitoring site visit, the Monitoring Team found there were varying levels of competency in facilitation displayed among those who had been certified. For example, in the ISP meeting for Individual #1, the facilitator was unfamiliar with the contents of some of the ISP assessments and lacked skill in both discussing living options with a reluctant LAR as well as guiding the IDT through the Integrated Risk Rating process. Some of the lack of competency displayed by certified facilitators may result from the size of the workload for which each of these four are responsible. The Facility continued to devote considerable resources to training, monitoring, and coaching for QDDPs, both new and current, an effort the Monitoring Team commends; however, the outcome of producing competent facilitators has not been achieved. The Facility should evaluate its training and redouble its efforts to develop competency among the QDDPs, both the	Noncompliance

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		currently certified and those yet to be deemed competent. The assigned QDDP also remained responsible for ensuring the monitoring and revision of treatments, services, and supports. The Monitoring Team found the QDDP did not consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed as described below under Provisions F2a6 and F2d. Conclusion: This provision was found to be not in compliance.	
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.	Composition and Participation of IDT The Facility tracked the attendance of IDT members at annual ISP meetings and in the most recent quarter reported an average of 95% of members participated. The QA Department reported these data were collected by a review of the completed attendance sheets. This provides for only a partial assessment of actual participation as a member of the IDT. Examples included: • For the ISP meeting for Individual #1, there were several significant concerns related to participation that would not be always reflected in the attendance documentation. The OT did not attend, although there were issues to be discussed that would require such participation. The QDDP stated the OT had not given a reason for non-attendance. In addition, although the attendance sheet indicated the DCPs participated, the reality was the DCP was not present for most of the meeting. The psychologist, while an active participant when present, was in and out of the meeting on several occasions. • While SLP presence during ISPs and IDTs had shown some improvement, SLPs remained absent in many of the facets of care required by their profession. Refer to Section R. Extent of Individual participation in ISP Meaningful participation by Individuals in the ISP continued to be very limited. This finding was consistent with the Facility's own self-rating in the Self-Assessment. 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. 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	Noncompliance

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		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 PFA process and 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 IDT to explore the PFA areas with the individual. The portfolio could then be revised for the ISP meeting based on the PFA results. This would make the ISP a much more comprehensible, participatory and positive experience. It was noted by the Director of CFR that the Facility intended to develop something along this line. <u>Conclusion:</u> This provision was found to be not in compliance.	
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.	<u>Extent to which assessments are conducted routinely</u> Assessments for the ISP were often not completed on a timely basis. The expectations remained that assessments would be posted no later than ten days prior to the meeting, such that all team members could review the findings and recommendations in preparation for the meeting. The Monitoring Team found that even for the ISPs held during the week of the compliance visit, not all assessments were available. The Monitoring Team also reviewed the assessments available on the shared drive for a sample of ISPs upcoming over the next ten days. Zero of ten (0%) had all required assessments available and/or posted by the required date. This consistent tardiness in the completion of ISP assessments was confirmed by the Facility's own tracking data, although the QA Department reported these data were unreliable due to a flaw in its data collection methodology that had just recently been corrected. Other examples found throughout this report included: • As reported in Section S, none of the individuals included in a sample reviewed had been provided all necessary assessments. • As reported in Section M, Facility data in the Self-Assessment indicated 17% of nursing assessments for the month of December, 2011, were completed within the specified time frame, and 52% for ISP meetings held in the month of January, 2012. It was also noted that DADS policy calls for the PFA to be completed and posted 90 days prior to the ISP date, such that all disciplines could incorporate the individual's preferences and individual goals into their assessments and recommendations. DSSLC continued to implement a pilot project in which a Personal Focus Interview (PFI) was to be completed in a series of interviews and meetings coordinated by a designated QA Auditor. The pilot policy (DSSLC Policy CMGT-12.01 Personal Support Planning Process Pilot Project Personal Focus Assessment and Facilitation, dated 8/5/11) indicated that these interviews should occur at or before the Third Quarterly Review by September 2012. The QA Auditor indicated she believed the Facility was on track to achieve a 90	Noncompliance

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		day timeline by the fall of 2012. At present, however, PFAs tend to be posted to the shared drive approximately ten working days before the ISP meeting, thereby negating the intent that discipline-specific assessments should incorporate the findings of individual's preferences. The Monitoring Team noted the pilot policy indicated that the success of the project would be evaluated based on feedback from the ISP consultants and the Settlement Agreement Monitors as well as data from the ISP Monitoring tool. The QA Auditor was not aware of any evaluative process underway. It is recommended an evaluation be undertaken as soon as possible and should be measured against specific outcomes it was designed to achieve. <u>Extent to which to which assessments are conducted in response to significant changes</u> The Monitoring Team found that there were some examples in which assessments were being updated in response to significant changes. For example, as reported in Section O, 12 of 13 (92%), individuals who were diagnosed and/or hospitalized with a PNM issue were assessed by the PNMT or IDT. There were still many instances, however, in which assessments were not updated when the need arose. Examples included: • As reported in Section M, the quarterly Comprehensive Nursing Assessments were not updated when there was a significant change in health status. • As reported in Section K, documentation provided during the current site visit revealed circumstances in which individuals living at DSSLC had experienced health problems involving cognitive and adaptive impairment, and for whom no routine or updated assessment of those abilities had been provided. <u>Extent to which to which assessments are of sufficient quality to reliably identify the individual's strengths, preferences and needs</u> There were some improvements noted in some of the assessment processes at DSSLC. Examples include: • As described in Section L, there was evidence of significant improvement of medical assessments by the clinicians. In one sample of fifteen assessments, 15 (100%) appeared to be thorough. • As described in Section S, the Functional Skills Assessment (FSA) currently in use reflected advancement from the previous PALS assessment, although it still had significant limitations as discussed in more detail below. • As described in Section N, the Monitoring Team noted that, while not yet compliant, the Clinical Pharmacists had significantly improved the overall quality and timeliness of the QDRR process. Overall, assessments were still not routinely of sufficient quality to reliably identify the individual's strengths, preferences and needs. The Facility relied on two assessment processes, the Functional Skills Assessment (FSA) and the Personal Focus Assessment	

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		(PFA) in particular, to identify individuals' strengths, preferences and needs. The Monitoring Team found there were significant limitations in these current processes. Examples included: • The Monitoring Team found that the PFA was not effectively providing a basis for describing an optimistic living vision as originally intended. As reported in Section S, the current PFA process had significant limitations even as nothing more than a preference survey. Preferences identified through the PFA were noted to be entirely subjective and frequently based upon anecdotal evidence. • Also as reported in Section S, the most common process used at DSSLC to assess adaptive skills and habilitative needs was the Functional Skill Assessment (FSA). While the FSA reflected advancement from the previous PALS assessment, it was not clear that the protocol was sufficient for skills assessment. The FSA lacked the rigor necessary to accurately identify specific, task-related strengths. This limited the PST in efforts to adequately identifying personal strengths and to recognize the ability of each person to engage in routine activities associated with independence and self-care. • As reported in Section R, communication assessments were not comprehensive enough to allow for the identification and potential expansion of communication skills. Another concern was that 12 assessments reviewed were generic in that they were identical with the exception of a few sentences. These assessments focused on the removal of Alternative and Augmentative Communication (AAC) and implementation of Environmental Control (EC). Other examples of failures to adequately identify strengths, needs and preferences in discipline specific assessments included: • As reported in Section R, although a plan was in place to provide all individuals with a communication assessment, the assessments were not comprehensive as they lacked identification of communications strengths, consistent functional programs, and strategies to enhance or facilitate communication. • Also reported under Section R was a concern that 12 assessments reviewed were generic in that they were identical with the exception of a few sentences, and the recommendations for these 12 assessments were also identical. This similarity in assessments and recommendations represents a lack of an individualized communication assessment • As reported in Section O, only three of 27 Individuals (11%) were provided with a comprehensive assessment by the Physical and Nutritional Management (PNM) team and/or IDT 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. • As described in Section M, a review of three community discharge nursing	

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		assessments found they were not adequate to provide comprehensive discharge plans that included special instructions for training the receiving agency staff. • As described in Section T, the assessments for Community Living Discharge Plans did not consistently address the services and supports needed for each individual to make a successful transition, nor how the individual's preferences could be accommodated and supported in a community setting. <u>Conclusion:</u> This provision was found to be not in compliance.	
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.	<u>Extent to which assessment results are used to develop ISPs</u> 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, an ISP that outlines the protections, services, and supports to be provided to the individual. As described in Provision F1c, assessments required to develop an appropriate ISP meeting were frequently not done in time for IDT members to review each other's assessments prior to the ISP meeting, nor were assessments completed with sufficient thoroughness. Even when the results of this flawed assessment process were used in the development of the ISP, the IDTs did not consistently use the available results appropriately to develop, implement, and revise the ISP as necessary. For example, as described further in Provision S1, in a sample of 13 individuals comparing assessments with skill acquisition programs (SAPs), the Monitoring Team found striking infrequency with which the Facility acted to ensure that assessment findings were reflected in actual SAPs. The reviewed ISPs seldom presented assessment findings in relation to teaching new skills. Furthermore, in several instances, the assessment information that was presented did not support the training goals or SAPs that had been developed for the individuals in the sample. In one example cited, Individual #297 was provided an SAP to teach looking both ways before crossing the street. The Functional Skills Assessment (FSA) reflected that the individual possessed and demonstrated the ability to cross streets independently. In addition to the examples cited in Provision S1, other examples of the failure to ensure adequate assessments were used to develop appropriate ISP strategies included: • Individual #476 was admitted to DSSLC from another SSLC in January 2012. At the ISP meeting, the IDT determined the individual had challenging behaviors and a history of inappropriate interaction with women. The psychologist indicated this history would present a barrier to community living. The IDT then agreed the PBSP would then include teaching the individual to shake hands upon greeting. The ISP also indicated the individual would attend on-campus dances,	Noncompliance

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		but provided no further methodology as to how this activity might support appropriate behavior toward women. There was no psychological assessment or functional analysis to provide the basis for these treatment decisions. As these behaviors were reported to be of a long-standing nature, an assessment of previous attempts at treatment should have been completed to attempt to ascertain whether these would be appropriate, adequate or effective interventions. • As reported in Provision R3, the ISPs 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. • As reported in Section L, in a review of records for ten individuals with a diagnosis of Down's Syndrome, the Monitoring Team found that zero of ten (0%) ensured appropriate delineation for necessary monitoring, risks, and supports and services in the ISP and physical therapy (PT) assessments; and 0 (0%) of the annual medical assessments included an appropriate plan specific for Down Syndrome. <u>Conclusion:</u> This provision was found to be not in compliance.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	The 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 IDT as a whole and the members individually serve as the state's qualified professionals for this purpose. While DADS policy and the SA explicitly state that the decision of the LAR regarding community placement is to be honored, team members at DSSLC had been provided clarification and training as to their individual responsibilities to make a recommendation about the most integrated setting both in their individual assessments as well as during the ISP discussion of living options. In addition, The Director of CFR had provided training on the Olmstead decision and the identification of the most integrated setting to a variety of disciplines. The Monitoring Team attended three ISP annual planning meetings and reviewed seven ISPs completed since last compliance visit, as measures of the IDTs' 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 three of three ISP 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.	Noncompliance

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		On the whole, however, IDTs were not yet proficient in identifying the most integrated setting appropriate to an individual's needs. IDTs had been provided clarification and training as to their individual responsibilities to make a specific recommendation about the most integrated setting. The State Office had provided a directive that each SSLC team member must include in his/her assessment/evaluation a recommendation regarding the individual's appropriateness for transition to a more integrated setting, and delineation of the supports the individual would need. In addition to assessors providing recommendations in each of their assessments, the determination of the professionals on the team should be documented clearly in the ISP. The professionals' recommendation should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition. The portion of the directive for each discipline to include recommendations regarding the most integrated setting and supports/services needed in that setting had not yet been fully implemented at DSSLC. The Monitoring Team reviewed seven recent ISPs, including the assessment packets and attended three ISP annual planning meetings to evaluate compliance with this provision. Overall, each team member did not consistently include a determination in his/her assessment as to most integrated setting as required. The Monitoring Team was provided with 39 discipline specific assessments related to the seven ISPs reviewed. Of these 39, sixteen (41%) provided such a determination. Of the seven ISPs reviewed, five were in the new ISP format, while two were in the older format. The new format had distinct sections for documenting the discipline-specific opinions regarding the most integrated setting appropriate to an individual's needs as well as the IDT determination. It was not apparent that the new format had yielded a more integrated discussion of the most integrated setting. In the ISP meetings observed, the individual disciplines were each asked to provide their professional findings and opinions in this regard, but there was limited integrated discussion. In the ISPs reviewed, there was documentation, if somewhat haphazard in nature, in the section for discipline-specific determinations, but in most cases there were varied opinions among the team members. There was no documentation of any integrated discussion held to attempt to reconcile these various opinions or to discuss how needs identified as obstacles might be met in a community setting. For the most part, it appeared the IDTs and individual members were complying with a requirement to complete certain sections without a real understanding of the intent. Examples included: • For Individual #336, three of the ISP assessments provided no determination about most integrated setting, three indicated supports and services could be provided in the community and two indicated they could not. It was very	

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		difficult to follow the discussion record in this ISP, but it was clear there was no discussion leading to a consensus about the most integrated living option. Nevertheless, the ISP documented that DSSLC was the recommended living option. • For Individual #537, the Living Options Discipline Recommendations section indicated that the QDDP, Residential Coordinator, Behavior Analyst and Psychiatrist all agreed the individual's needs could not be met in the community. The Psychological assessment, however, stated the individual's needs could be met in the community with close collaboration among medical, nursing and psychiatric services and consideration of an increased level of supervision. The OT/PT assessment also indicated needs could be met in the community. There was no documentation of an integrated discussion that would resolve these differences of opinion; however, the final IDT determination of living option indicated the individual should continue to live at DSSLC due primarily to LAR request. • For Individual #235, the ISP documented that Nursing, Medical, Vocational and Dental all agreed that services and supports could be provided in a community setting, but OT/PT disagreed. There was no documentation of an integrated discussion to reach consensus, and the final living option determination was DSSLC based on an agreement of the IDT to follow the wishes of the LAR and the individual's lack of awareness of living options. IDT 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 unreasonable to expect that LARs who are fearful or reluctant about community living will be influenced by the discussion at the annual ISP meeting; in fact, the opposite is usually the case. Families and LARs often come to the meeting feeling in a defensive posture about this subject, which is not conducive to a discussion that might highlight the potential advantages of community living. It is again recommended the Workgroup for Sections F, T and U develop strategies in this area that should include ongoing contact with families and LARs across the year. <u>Conclusion:</u> This provision was found to be not in compliance.	
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:		

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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:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	The Facility had begun on January 1, 2012 to use a revised ISP template that was developed in collaboration with its statewide consultants. It was not yet incorporated into statewide or local policy, but training had been provided to QDDPs on its use. <u>Extent to which ISP builds on the individual's preferences and strengths and prioritized needs</u> As described further in Provision S1, in a sample of 13 individuals comparing assessments with skill acquisition programs (SAPs), the Monitoring Team found that only eight percent (8%) were related to individuals' stated preferences. <u>Extent to which ISP provides an explanation for any need or barrier that is not addressed</u> IDTs did not consistently provide an explanation for any need or barrier that was not addressed. In none of the seven recent ISPs reviewed (0%) were barriers clearly identified and addressed. <u>Extent to which ISP encourages community participation</u> As reported under Section S, community outings have remained at relatively high levels. This was to be commended. This provision of the Settlement Agreement, however, addresses not only the quantity of community opportunities, but the provision of training in the community as well. In discussions with staff it was reported that many community outings include the implementation of SAPs. At the time of the site visit, however, there was not a system to track the number of actual training opportunities in the community or progress achieved through community training. 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. The Monitoring Team found that ISPs did not provide adequate strategies to encourage meaningful community participation. In a review of seven recent ISPs, zero of seven (0%) evidenced any meaningful community integration strategies. Instead, these were typically limited to stating the individual would have opportunities to participate in various community outings. For many of these individuals, community awareness and participation had been identified as obstacles to living in the most integrated setting, but IDTs did little to develop community integration strategies that would address these obstacles. For example: • As reported in Section T, Individual #537 had indicated a desire to live in a	Noncompliance

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		group home, but the IDT determined that a lack of awareness of community living options was one of several obstacles. The Action Plan stated in the ISP was to increase knowledge of community living options, but the action steps were 1) that the individual had past failed placements and had a PBSP, 2) that the IDT had concluded there were severe behavior problems that precluded community living, 3) that medical conditions presented a "very unsafe potential for community placement," and 4) that the individual would continue semi-monthly overnight visits to the parent's home on a contingency basis. None of these addressed the stated obstacle of lack of community awareness. These obstacles would not preclude the individual's learning about community options and such learning might even be fashioned to encourage community-appropriate behaviors. The Facility had initiated a program designed to provide increased work opportunities in community settings. Since the previous site visit, DSSLC reported that Impressions had begun operations. Impressions was a boutique store in downtown Denton where pottery, jewelry and other crafts were made and sold. The intent was to use the program as a retail outlet and training site. As Impressions was relatively new, it was unclear how many individuals from DSSLC were actively involved in the program. <u>Conclusion:</u> This provision was found to be not in compliance.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	<u>Extent to which ISP specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain identified outcomes related to each preference</u> As described in Provision F2a4 and further in Section S, ISP programs did not contain the requisite essential components of skill acquisition programs such as operational definitions of teaching targets, discriminative stimuli, consequences, and teaching instructions. <u>Extent to which ISP identifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to overcome identified barriers to living in the most integrated setting</u> Barriers to living in the most integrated setting did not always lead to goals, objectives, or service strategies. The ISP did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain outcomes related to identified barriers to living in the most integrated setting appropriate to his/her needs. As reported in Section T, the Monitoring Team found that obstacles to transition to the most integrated setting were not consistently appropriately identified or addressed. Only one of seven (14%) recent ISPs reviewed evidenced some proficiency in this regard. Also see Provision F1e above.	Noncompliance

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		Conclusion: This provision was found to be not in compliance.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Extent to which ISP integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions The Facility demonstrated some progress toward integrated treatment including considerable effort made in integrating behavioral and psychiatric assessments and treatments. Although it was clear that teams were trying to identify and incorporate individuals' preferences and work in a more integrated manner, the resulting ISPs still did not show an integrated plan that set forth the full array of protections, supports, and services individuals required. It was not yet clear whether the new template would be used effectively as a tool to assist the IDTs to achieve such integrated plans, or whether teams would simply use the new format without also adjusting their thought processes and problem-solving techniques. Additional and extensive training was likely to be needed to prepare teams to think creatively about the needs and preferences of individuals and how to address them on a person-by-person basis. Too often, the Monitoring Team has seen the IDTs merely adapt old processes such that they fit into the new tool. The Monitoring Team looks forward to reviewing the implementation of this process at its next visit. Examples that demonstrated that ISPs still failed overall to consistently integrate all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for an individual included: • As reported under Provision R, ISPs 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 is need to not just restate the assessment but to draw connections to how the provided assessment and recommendations can be intertwined with all objectives and SAPs. Strategies to increase communication and understanding must be present in all aspects of care. • As reported in Section M, zero of 22 (0%) Acute Care Plans demonstrated they were developed in collaboration with other relevant disciplines. • As reported in Section O, PNMPs and dining plans were not formally developed with input from the IDT. In zero of 27 records reviewed (0%), PNMPs were clearly developed with input from the IDT with an emphasis on DCPs, medical/nursing staff, and behavioral staff (if appropriate). Per record review, there was evidence in the ISPs that the PNMPs were included, but there was no	Noncompliance

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		evidence of discussion or input from other team members. Conclusion: This provision was found to be not in compliance.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Extent to which ISP identifies: • Methods for implementation: As reported in Provision S1, the Facility had demonstrated some progress in this area, including a more structured SAP format and an increase in the inclusion of sufficient opportunities for the target skill or behavior to be displayed. Despite these improvements, DSSLC had failed to improve in several areas. Methods for implementation were found to be lacking in many key components necessary to effectively promote learning, including: o SAPs at DSSLC often did not reflect adherence to the basic principles of sequential training. o Frequently, goal statements lacked the content and precision necessary for goal statements. As a result, it often was not possible to identify what was expected from the individual or how progress was to be measured. o The training programs reviewed during the current site visit often lacked details and failed to ensure that training would be implemented consistently. o In the majority of skill acquisition programs reviewed, the SAPs did not specify the number of teaching trials to be provided. • Timeframes for completion: The SAPs at DSSLC also often failed to include any time frame for completion or included measures other than time that were not defined in the SAP. It was also found, as described in Section S, that individuals were frequently required to demonstrate mastery for extended durations. • Responsible Staff: The SAP format in use at DSSLC did not include a section in which the person(s) responsible for data collection could be identified; rather, it indicated only time and place for implementation. Conclusion: This provision was found to be not in compliance.	Noncompliance
	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	Extent to which interventions, strategies, and supports are practical and functional: In many instances, the interventions, strategies, and supports prescribed in the ISP were not practical or functional in the Facility nor in a community setting. As described above, many interventions, strategies, and supports were provided on a very intermittent and even random basis, which would render them to be not of any practical function in an individual's life. Many examples of the interventions, strategies, and supports that were not practical or functional may be found in Section S.	Noncompliance

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	community settings; and	Conclusion: This provision was found to be not in compliance.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	Extent to which ISP identifies data and/or documentation and the frequency of data collection in order to permit the objective analysis of the individual's progress The majority of SAPs provided no instructions for data collection other than the code to use for recording a prompt level. It was also common to discover SAPs that provided only a schedule for data collection. Extent to which ISP identifies the persons responsible for the data collection and the persons responsible for data review As noted above in Provision F2a4, the SAP format in use at DSSLC did not include a section in which the person(s) responsible for data collection could be identified; rather, it indicated only time and place for implementation. Likewise, the SAP format did not provide for the specific identification of person or position as the individual responsible for program review. The ISP Action Plans did identify responsibility by position to an extent, but did not clearly delineate the specific responsibility of each position. For example, an Action Plan for Individual #537 designated responsibility for an activity to the "DSP, ATC, QDDP," but there was no information as to the specific responsibilities assigned to each of these positions. Conclusion: This provision was found to be not in compliance.	Noncompliance
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.	Extent to which 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 among the goals, objectives, anticipated outcomes, services, supports, and treatments in the ISP, as described throughout this Section F. For example, there were many instances in which community participation and integration was identified as an outcome to be achieved. The Monitoring Team found an almost complete lack of coordination in the ISP of the community participation objectives, which typically stated only that an individual would have opportunities to go on community outings, with skill acquisition programs that could have community components such as money management and pedestrian safety; with social, behavioral or communication strategies; and even with community living options awareness objectives. Conclusion: This provision was found to be not in compliance.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with	Extent to which ISP is accessible to staff Staff were consistently able to locate the record and the programs found in the ISP.	Noncompliance

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	full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	Although the Monitoring Team found staff were not consistently able to describe the contents of the ISP or programs without referring to the documents (see below), they were able to locate the information with relative ease when asked. For example, as reported in Section O, when asked, ten of ten (100%) staff knew where the PNMP was located. Extent to which ISP is comprehensible to staff In addition, twenty-five staff were interviewed as to issues related to comprehensibility and 100% reported that SAPs were easy to understand and implement. Observations and review of program data indicated that, in terms of outcomes the ISP did not appear to be comprehensible to the staff responsible for implementing it, as there were many instances in which staff could not describe supports contained in the ISP or did not implement them as called for in the ISP. Examples included: • During the current site visit, DSSLC reported that SAPs were implemented correctly during 58.2% of observations conducted since September 2011. As reported in Provision S2, observations conducted by the Monitoring Team failed to capture the implementation of any SAPs at all during this compliance visit. This called into question whether staff understood the ISP and how to implement it. • Six of 25 staff (24%) were unable to describe an individual's SAP without first referencing the written program. • Staff did not understand rationale of recommendations and interventions as evidenced by failure to verbalize 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 ten DCPs: o What kind of transfer do they require? (100%) o What do you look for to ensure the individual is in the correct position? (10%) o Why does the individual need thickened liquids? (40%) o Why does individual eat modified texture foods? (50%) o Why does the individual require a specific utensil? (40%) o Why does the individual require a specific assistance technique? (0%) Conclusion: This provision was found to be not in compliance.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that,	Monthly review of progress DSSLC did demonstrate notable progress in relation to ensuring that treatment data were reviewed at least monthly by the psychology staff, and this was to be commended. Overall, however, the IDTs did not consistently ensure assessment of progress was noted	Noncompliance

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	at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	in that a monthly basis, or more frequently as needed, or make revisions if there was a lack of expected progress. The Monitoring Team found that Quarterly Reviews were not consistently completed in a timely fashion nor in a way that provided for meaningful evaluation of progress or program revision. For example: • For Individual #1, the first quarterly review for the ISP dated 4/20/2011 was on 7/19/2011, but no additional quarterly review was documented until 2/17/2012, a period of about seven months. • For Individual #151, the Action Plan goal was for a decrease in self-injurious behavior to "20% or fewer total intervals" per month, but the data reported in the Quarterly Review indicated 25, 13 and 76 episodes. There was no indication anywhere in the review how these data related to the percentage/interval required for success. <u>Extent to which ISPs are modified as appropriate</u> The failure to complete timely reviews obviously produced a concomitant negative outcome in terms of appropriate modification. Examples included: • As reported in Section K, of 8 PBSPs reviewed, only three (38%) reflected either appropriate revisions following increases in treatment targets or an adequate response to treatment that negated the need for any revision. For the remaining 5 PBSPs (62%), poor treatment response did not result in a change in the PBSP. • For Individual #151's, Action Plan goal cited immediately above, there was no indication anywhere in the review that the IDT considered what the meaning of these variable data might be, nor was there any evidence the IDT took any action. It simply indicated staff should continue to follow the PBSP. <u>Conclusion:</u> This provision was found to be not in compliance.	
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	<u>Extent and adequacy of competency-based training for staff responsible for development of ISPs</u> As documented in previous reports, training on ISPs had been standardized across the SSLCs. Supporting Visions: Personal Support Planning was the standard training curriculum for personal supports planning. In addition, QDDPs were trained in facilitation skills using the Q Construction curriculum. Additional training sessions and resources had been initiated. These included: • The Director of CFR had provided training to QDDPs and Social Workers on identification of obstacles. • The Director of CFR had provided training to various disciplines on the Olmstead decision and IDT members' responsibilities for making a recommendation as to the most integrated setting. • The State had hired consultants to provide training, and work hands-on with	Noncompliance

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	employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	teams on the ISP process. The consultants had provided some training to DSSLC IDTs. Additional training should be provided on how to develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. It will be important to provide teams with the tools necessary to focus on individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs. <u>Extent and adequacy of competency-based training for staff responsible for implementation of ISPs</u> The Monitoring Team found staff were not adequately provided with competency-based training. This finding was made by the lack of active treatment and engagement observed and by the lack of fluency with which staff were able to discuss the strategies, supports and interventions included in an individual's ISP without referring to the record. Examples included: • As reported under Provision S, in interviews with DCPs, 20 of 25 (80%) reported that adequate training was provided on SAPs; however, this finding was not borne out by observations of the Monitoring Team indicating a lack of active treatment and engagement and by the lack of fluency with which staff were able to discuss the strategies, supports and interventions included in an individual's ISP without referring to the record. • As reported in Section M, the Monitoring Team found DCPs were trained on Health Care Plans by the nursing staff and that It was positive to find that the special instructions developed for the direct care professionals were more individualized to meet individuals' health care they were responsible for carrying out, but the Facility reported there was not a competency component. <u>Conclusion:</u> This provision was found to be not in compliance.	
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	<u>Extent to which ISPs are developed within 30 days of admission</u> DSSLC reported three admissions in the last six months. Each of the three had an ISP dated within that 30 day period. With the exception of a Nutrition Assessment for Individual #476, which was not completed until more than one month after the ISP meeting date, all assessments provided for review were dated within the 30 day period. It was also noted that Individual #476 did not have a current or updated Psychological/Functional Assessment included in the packet. This was significant given the psychologist recommended at the ISP against community living due to behavioral challenges, a concern further discussed under Provisions F1d above and T1c1 below.	Noncompliance

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	preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	<u>Extent to which ISPs are revised annually and as needed:</u> The Monitoring Team reviewed a list of ISP dates provided by the Facility. For a sample of 45 individuals that included representation from all living units, 100% were completed on a timely basis. As described in Provision F2d, however, the IDT did not consistently undertake revisions as needed based on progress or lack thereof. <u>Extent to which ISPs are put into effect within thirty days of preparation</u> The Facility did not consistently implement ISPs within 30 days of preparation. For example: • For Individual #679, the ISP was completed on 10/10/11, but almost all implementation dates were recorded as 1/30/12 and a request for copies of all SAPs since admission yielded only data that began being collected in February 2012. • For Individual #235, the ISP date was 12/16/11, but no completed data sheets were provided as requested for review to verify implementation dates, and the Quarterly Review provided documented the first period in the quarter was 2/16/12. • For Individual #122, the ISP date was 11/16/11, but only one data sheet was provided for review that demonstrated any data had been collected before January 2012. <u>Conclusion:</u> This provision was found to be not in compliance. The Facility had made substantial progress in ensuring that ISPs were developed within the required timeframes, but did not yet consistently implement ISPs within 30 days of preparation.	
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. Very few of these (eight) had yet been completed according to the QA Director, so there is very little basis upon which to evaluate compliance with this provision at this time. The Facility tracked annual assessments filed within the 10 day requirement, but found these data were confounded by a misinterpretation of the data entry staff. This rendered much of the data to date unusable, but the Facility reported the problem had been corrected and reliable data should be available at the next compliance visit. The Facility also tracked attendance data, but as described under Provision F1b above, these data could did not necessarily present an accurate or reliable picture of meaningful participation by IDT members.	Noncompliance

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		The Workgroup for Sections F, T and U should work with the QA Department to evaluate how these processes and the data they produce can be fully integrated into a more comprehensive QA process that addresses critical outcomes. Conclusion: This provision was found to be not in compliance.	

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

1. The Facility should prioritize the development of an overall QA plan involving monitoring tools, QDDP audit tools, active treatment tools and any other applicable tools as described in the Action Plans, dated 03/08/2012. (Self-Assessment)
2. The Facility should evaluate its training for QDDPs and redouble its efforts to develop competency among the QDDPs, both the currently certified and those yet to be deemed competent. (Provision F1a)
3. In order to make the ISP a much more comprehensible, participatory and positive experience for individuals, 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. (Provision F1b)
4. An evaluation of the PFI pilot project should be undertaken as soon as possible and should be measured against the specific outcomes it was designed to achieve. (Provision F1c)
5. Additional training should be provided on how to develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. (Provision F2e)
6. The Workgroup for Sections F, T and U should work with the QA Department to evaluate how current monitoring processes and the data they produce can be fully integrated into a more comprehensive QA process that addresses key outcomes.

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 Self-assessment CV4 2/2/12 2. DSSLC Action Plan 3/8/12 3. Presentation Book for Sections G and H 4. DADS Policy 009.1 Medical Care 2/16/11 5. DADS Draft Policy Minimum and Integrated Clinical Services 1/12/10 6. DSSLC Policy CMGMT 03 Integration of Clinical Services 3/27/12 7. ISPs, CLDPs, and other documents reviewed by the Monitoring Team 8. Consultation reports for Individuals #21, #42, #49, #53, #126, #279, #285, #331, #337, #367, #401, #409, #602, #622, and #679 **People Interviewed:** 1. Group interview with Dr. Stephen Kubala, Director of Medical Services, Randy Spence, Director of Behavioral Services, Donna Groves, Director of Habilitation, and Nancy Condon, Director of DSSKC **Meeting Attended/Observations:** 1. ISP Annual Planning Meeting for Individual #53 2. Meetings attended by Monitoring Team members noted in several report Sections
	Facility Self-Assessment: The Facility Self-Assessment included a list for each provision of the activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating with rationale for the rating decision. Most of the results reported described actions that had occurred, and some provided data from reviews of documents, interviews, and observations. The Facility found that neither provision of this section was in compliance; the Monitoring Team concurs. For G1, one activity was review of medical provider quality assurance audits, three activities involved review of clinician attendance and participation at meetings (weekly Morning Provider, IMRT, and ISP meetings), and one was review of clinical indicators to identify trends. Meeting participation was not reported in results; attendance was reported. In fact, although attendance is necessary, it is not sufficient; some assessment of actual participation (or of the outcomes of participation, just as evidence that several disciplines provide input into supports and services to meet a single goal—such as providing opportunities to learn handwashing as a pre-SAMS goal, an activity at a worksite, as a step in learning food preparation skills, and as part of a bedtime routine used as part of a program to reduce resistance to going to sleep) would provide better evidence of integrated clinical services. For G2, the activities involved review of external and internal medical audits, and review of a sample of recent consults "to see if the new system is being used effectively." The self-assessment itself did not describe what was specifically measured as an indication of "used effectively." The Monitoring Team checked only whether review was documented on the new form (for medical consultations) and IPNs; for

	medical consultations, the data for IPN documentation was relatively similar to the self-assessment data for "used effectively." The Facility also provided an action plan for reaching compliance. For each provision, this plan described actions that were in process or not yet started. Rather than an overall plan for ensuring records are accurate, timely, accessible, and used for making decisions, the action plan is a set of different activities to accomplish specific tasks. Although the tasks themselves may be important, they do not establish a sequential order of actions that build on each other to ensure integrated clinical services and instead are simply a listing of related and unrelated actions. Many of the actions have a status of "Complete and ongoing." Certainly, ensuring completed improvements are maintained is important, but the action plan to build from these toward a desired outcome. For example, Action Step #7 under Provision G1 is, "Morning meeting in Infirmary shall include nursing and provider staff on a daily basis and others as needed." This may be a means the Facility chooses for ensuring communication across providers on a daily basis, but there is no further action to build from there either by expanding the participants, by building processes for that communication to result in joint and collaborative planning, or to use that for any other purpose such as monitoring of outcomes of system improvements or determining corrective actions based on review of clinical indicators (all of which are among the multiple possibilities for using such a meeting, and none are specific recommendations from the Monitoring Team but are examples of possible next steps). Action Step #9 is to have a morning meeting in the Infirmary that includes all discipline heads and the Center Director to discuss systemic issues, but there is no indication of whether this is in any way related to the daily meeting, and again there is no indication of additional steps to build onto this one to move toward compliance.
	Summary of Monitor's Assessment: The Facility has continued to expand steps toward providing clinical services in an integrated manner. The Facility implemented policy that, while it provides few expectations or procedures, it makes clear the expectation of integrated services**.** Participation in the ISP process had continued to improve but had not yet reached a level of integrated planning. Participation across disciplines had increased in both IDT meetings and committees and workgroups working on systemic improvements. For example, 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 IDT as well, and PBSPs provided evidence of effective integration of materials from psychiatry and psychology in the overall formulation. At the same time, there were also examples in which planning and assessment did not evidence an integrated approach. Planning of services and supports did not consistently indicate collaborative joint planning. The Facility implemented a new medical consultant report form with a back page for documentation of review and response to recommendations; documentation was to go there and in the IPN. Facility physicians consistently documented review on the consultation forms (although some dates were not provided) but not consistently in the IPN.

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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 continued to expand steps toward providing clinical services in an integrated manner. The Facility had implemented policy CMGMT 03 Integration of Clinical Services (effective 3/27/12). This recently implemented policy listed numerous areas in which integrated discussion and action should occur, and which disciplines should participate. These ranged from committees to dental/medical treatment to who documents in Integrated Progress Notes to a master schedule. Although the policy provides few expectations or procedures, it makes clear the expectation that integrated services will be a purpose of all these venues. 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 repeated 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. Participation in the ISP process had continued to improve but had not yet reached a level of integrated planning. Examples of improvement included: • As reported in Provision J8, a positive development was the increased participation of psychiatrists in annual ISP meetings. Per self-assessment, since September 2011, psychiatrists' attendance in ISP meetings has been 100%. However, observation at the ISP annual planning meeting for Individual #53 indicated no psychiatrist was present; as the individual did not evidence psychiatric needs and was not prescribed psychotropic medication, there was no indication of need for a psychiatrist to be present, but the self-assessment data should specify whether the percent is of all meetings or of meetings of people receiving psychiatric services. • As reported in Provision J10, the main place in the Facility clinical process where discussions about medication (including risk/benefit analysis) took place was the psychiatric clinic (PMR and QMR). Typically, IDT participation in the clinics included the psychiatrist, QDDP, nurse case manager, psychologist and Direct Care Professionals (DCP). Primary care physicians (PCPs) attended when possible. Medication issues broadly, including discussions about risk/benefit, could also be part of any IDT discussion. Facility functions, for example the PRC, P&TC, and the medical morning report, were other venues where these issues	Noncompliance

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		were also discussed. • For individuals who had active pressure ulcers, there was documented evidence in the records and/or through emails that the Wound Care Nurse collaborated with other relevant members of the individuals' IDT to provide integrated care. However, there were also examples in which planning and assessment did not evidence an integrated approach. For example: • Although the Facility reported, in the self-assessment for Provision F1, 95% attendance by IDT members at annual ISP planning meetings. However, for the ISP meeting for Individual #1, there were issues that required the participation of the Occupational Therapist (OT), but that person was not in attendance. Furthermore, the DCP was not present for most of the meeting, and psychologist was in and out of the meeting. At the ISP annual planning meeting for Individual #53, the DCP left when the individual indicated wanting to leave; furthermore, there were several issues that required information that an afternoon shift DCP could have provided, but only a morning DCP was present. However, the IDT members participated actively in discussion. Further, for this individual with jaw muscle issues that affected both dining and dental treatment, there was no speech and language pathologist (SLP) present nor any referral or discussion of whether the SLP could provide services or supports to address this issue. • Planning of services and supports did not consistently indicate collaborative joint planning. At the ISP annual planning meeting for Individual #53, there was discussion of implementing a handwashing program; the nurse reported that there had been a program for preparation for self-administration of medication (SAMS) to wash hands, but it had been they "are moving on." There was no discussion of collaboration, such as using the pre-SAMS program as a basis for generalization training in other settings and no indication that the decision to "move on" from handwashing had been made through an integrated planning process. Instead, on discipline was proposing a handwashing program and another said they were moving on from that. • As reported in Provision M3, care plans continued to lack adequate individualization to meet individuals' specific problems. The plans did not demonstrate integration with other disciplines to meet the total needs of individuals. • Also reported in Provision M3 was a finding that zero of 143 (0%) HMPs and zero of 22 (0%) ACPs were developed in collaboration with other relevant disciplines, with the exception of occasionally referring to other disciplines.	

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		There were other processes and venues that had developed for integrated clinical planning. For example: • As reported in Section O, 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 IDT as well. • As reported in Provision J8, the Facility revised the PBSP format to include a section for discussion regarding differentiation between functional behaviors and psychiatric symptoms. Psychiatry and psychology continued to have discipline-specific evaluations. For psychiatry it was the psychiatric evaluations and annual psychiatric updates. The Monitoring Team reviewed PBSPs that had been written recently and were presented by the Facility as examples in the Presentation Book. These were reviewed to get a sense of current Facility practice regarding combined formulations. The Monitoring Team found evidence of effective integration of materials from psychiatry and psychology in the overall formulation. In addition, as reported in Provision K4, substantial changes had been recently introduced to the data presentation and progress note format. These improvements included the integration of psychiatric target symptom tracking into the graphs of data. The report from the last compliance visit noted the positive working relationship between psychology and psychiatry; this has continued, and the actions noted above are indications that this working relationship is being effective in identifying improved services, to communicate information, and to facilitate the development of integrated and cohesive behavioral health care. • The unit meeting observed by the Monitoring Team, led by the unit's Behavior Analyst, was exemplary. The discussion about a restraint was interdisciplinary, included data review, and through the interdisciplinary discussion led to suggested changes in the Individual's Positive Behavior Support Plan (PBSP)and Individual Support Plan (ISP). • OT and PT completed annual assessments/updates collaboratively. • As reported in Provision M1, the Hospital Liaison Reports and all medical information were scanned into the hospital reports folder and into each individual's folder following hospital visits, in order to make it available to medical providers, nursing staff, and other relevant Interdisciplinary Team (IDT) members. The Hospital Liaison Nurses routinely attended morning rounds and reported on hospitalized individuals. They maintained ongoing communication with the RN Case Managers, Unit Directors, Qualified Developmental Disability Professionals (QDDPs), Wound care Nurse Occupational and/or Physical Therapist, and other IDT members as necessary. • In February, 2012, the Facility formulated a multidisciplinary/integrated monthly Diabetic Management Team Meeting. The purpose centered on how the	

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		team might impact the incidence and progression of diabetes and health related conditions in DSSLC's population. • As reported in Provision M1, the Infection Control Preventionist chairs the quarterly Infection Prevention Control Committee whose role was to oversee the development and implementation of the Infection Control Program. The Committee takes an integrated approach that included representatives from different departments, e.g., Medical Director, Facility Director, Assistant Facility Director, Chief Executive Nurse, Nursing Operations Officer, Dental Director, Pharmacy Director, Quality Assurance Nurse, Wound Care Nurse, Qualified Developmental Disability Professional, Habilitation Director, Housekeeping Director, and others as necessary. A review of the Quarterly Infection Prevention Control Committee minutes validated the participation of the interdisciplinary staff as well as discussion and disposition of identified infection control issues. <u>Conclusion</u> Provision G1 is not in compliance, but actions continue 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.	
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.	In response to a request for any Facility policy that guides Facility clinicians in performing and document reviews of recommendations from non-Facility clinicians, the Facility provided DADS Policy 009.1 Medical Care. This policy describes what must be written in consultation orders but does not provide guidance on the review that must be done when an outside consultant provides recommendations. The self-assessment and Dr. Kubala reported that the Facility implemented a new consultant report form with a back page for documentation of review and response to recommendations; documentation was to go there and in the IPN. As noted below, there was documentation on the consultation forms (although some dates were not provided) but not consistently in the IPN. This new consultation form is used only for medical consultations and completed by physicians. The date the form was implemented was not provided to the Monitoring Team, and the Action Plan stated the completion status was "Not Started"; however, a few consultation forms were reviewed that had the back page. The format documents through a checklist whether the consultant's recommendations are adopted, rejected, or adopted partially, and whether they are being recommended to the IDT for integration with existing supports and services. The Monitoring Team will review, at the next compliance visit, whether this form will result in clear documentation of responses by the Facility clinician and whether IPNs will include rationale and	Noncompliance

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		treatment plans. According to the self-assessment, the Facility reviewed two samples of medical consults to determine if the new system was effective. The self-assessment found 100% documentation in a review of a sample from each provider and 72.7% in a sample for a longer period of time. The Monitoring Team reviewed a sample of 11 medical consults and a sample of four MBSS consults. All the MBSS consults (100%) showed documentation in the IPN that the outcome was accepted. For medical consults, 11 of 11 (100%) used the consultation form, but only seven (64%) had documentation in the IPN to indicate acceptance or rejection of findings and recommendations, referral to the IDT, or action plans; two consultation forms were not dated but were signed. Because there was not consistent documentation in the IPN of acceptance, rejection, referral to the IDT, or action plans, this provision is not yet in compliance.	

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

1. DADS should revise and implement a policy on integrated clinical services that provides expectations and general procedures that can be operationalized by facilities. (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 ISPs and the active record. (Provision G1)

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 Self-assessment CV4 2/2/12 2. DSSLC Action Plan 3/8/12 3. Presentation Book for Sections G and H 4. DADS Policy 009.1 Medical Care 2/16/11 5. DADS Draft Policy Minimum and Integrated Clinical Services 1/12/10 6. DSSLC Policy CMGMT 03 Integration of Clinical Services 3/27/12 7. List of clinical indicators 8. Table of clinical indicators and reviewing authority 9. Graphs of key clinical indicators monthly data 2/11-3/12 10. Minutes of Diabetic Management Team of 2/14/12 11. List of Individuals Who Have Diabetes, 3/1/12 12. Incidence of Diabetes According to Home, undated 13. Diabetic Management Summary, aggregate and 15 individuals 14. Minutes of Physical and Nutritional Management Committee (PNMC) of 3/22/12 15. SPs, CLDPs, and other documents reviewed by the Monitoring Team **People Interviewed:** 1. Group interview with Dr. Stephen Kubala, Director of Medical Services, Randy Spence, Director of Behavioral Services, Donna Groves, Director of Habilitation, and Nancy Condon, Director of DSSKC **Meeting Attended/Observations:** 1. ISP Annual Planning Meeting for Individual #53 2. Meetings attended by Monitoring Team members noted in several report Sections
	Facility Self-Assessment: The Facility Self-Assessment included a list for each provision of the activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating with rationale for the rating decision. Most of the results reported described actions that had occurred, and some provided data from reviews of documents, interviews, and observations. The Facility found Provisions H2 to be in substantial compliance based on review of diagnoses to verify they correlate with ICD-9/DSM IV diagnoses (but reported only that "the ICD-9 is currently being used to give correct diagnosis" and did not mention DSM IV), that the most current ICD-9/DSM IV is available for use (but reported only that the ICD-9 codebook is being used), and that external monitors did not find problems related to inconsistency with ICD-9 and DSM IV codes. The self-assessment activities and findings did not address the other requirement of this provision, that the diagnoses clinically fit the corresponding assessments but stated in the self-rating that diagnoses clinically fit corresponding assessments.

	The Facility found all other provisions to be not yet in compliance, and the Monitoring Team concurs. It should be noted that all the reported self-assessment activities related to medical, dental, or physical and nutritional management (PNM) issues. Recognizing that many clinical indicators require that the contributions of other clinical disciplines should be part of planning and may have a significant impact, there remains a need to identify additional clinical indicators and to assess how the actions of those disciplines relate to compliance with requirements of this Section, such as whether their evaluations are performed on a regular basis and in response to changes in an individual's status, and whether interventions are timely and clinically appropriate. The Monitoring Team noted also that one activity and finding in the self-assessment for Provision H3 involved an outcome measure of reduction in pneumonia. The Monitoring Team welcomes the prospect of assessing progress in part through measures of their actual effects on the individual's served.
	Summary of Monitor's Assessment: The Facility had taken significant steps to develop clinical indicators and other processes that have great promise. At the same time, assessments continue not to be consistently timely or of adequate quality. The Facility will need to work assertively to turn potential into actual improvement in services. There had been improvements in both timeliness and comprehensiveness of some assessments, but problems remained regarding adequacy of assessments and evaluations, and provision of evaluations in response to changes in an individual's status. Assessments for the ISP were often not completed on a timely basis. Although assessments were now being done consistently following hospitalization for a PNM issue, there were still many examples in which assessments were not updated when there was a change in health status. Diagnoses were consistent with ICD-9 and DSM IV codes, but psychiatric evaluations did not always document clearly the rationale for the diagnoses or which symptoms were consistent with the diagnosis. The Facility did not have a system to ensure treatments and interventions are timely, and there were a number of examples in which interventions were not implemented or revised as needed. The development of an array of clinical indicators has the potential to both provide information to clinicians that may lead to more timely intervention and to assess whether treatments and interventions are initiated or revised as needed. The Facility had developed a set of clinical indicators that could be used to assess efficacy of treatments and interventions. The databases permitted these indicators to be tracked and reported facility-wide, by units, and by individuals. This was a notable area of progress but was not yet complete and was too recent to have had widespread effect on treatments, services, and supports. Although no provisions of this Section were yet in substantial compliance, several of the actions that had been implemented could lead toward compliance if the Facility takes assertive action to ensure that

	information is used thoughtfully to make decisions for both individual treatment and systemic action, and areas of systemic deficiency identified by the information gathered are addressed and improved.

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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.	Although there had been improvements in both timeliness and comprehensiveness of some assessments, problems remained regarding adequacy of assessments and evaluations, and provision of evaluations in response to changes in an individual's status. Assessments for the ISP were often not completed on a timely basis. Although assessments were now being done consistently following hospitalization for a PNM issue, there were still many examples in which assessments were not updated when there was a change in health status. <u>Timeliness of regular assessments and evaluations</u> As reported in Provision F1c, assessments for the ISP were often not completed on a timely basis. The expectations remained that assessments would be posted no later than ten days prior to the meeting, such that all team members could review the findings and recommendations in preparation for the meeting. The Monitoring Team found that even for the ISPs held during the week of the compliance visit, not all assessments were available. The Monitoring Team also reviewed the assessments available on the shared drive for a sample of ISPs upcoming over the next ten days. Zero of ten (0%) had all required assessments available and/or posted by the required date. Assessments for newly admitted individuals were completed timely. Communication assessments/screenings were completed within 30 days of admission for those individuals who were newly admitted. New admissions had received an OT/PT assessment. Psychiatric and psychological assessments for admissions were also completed timely. However, as reported in Provision K5, intellectual assessments were routinely more than five years old, and adaptive assessments were routinely more than one year old. Sixty-five percent of psychological assessments were over one year old. Furthermore, only 53% of sampled annual medical assessments were completed within 365 days. Nineteen of the 26 (73%) Annual and Quarterly Comprehensive Nursing Assessments reviewed were completed according to the individuals' ISP schedule. Although the assessments were not completed on time, they were completed after the due date. A communication master plan was provided to the Monitoring Team that outlines the	Noncompliance

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		assessment process. Per the master plan, all individuals would receive a revised comprehensive assessment by 12/31/2015. Individuals were assigned priority groups based on their level of communicative functioning and need. This plan would mean that not all individuals would receive a comprehensive assessment or reassessment for three more years. <u>Assessments and evaluations in response to changes in status</u> Some assessments were being updated in response to significant changes. For example, as reported in Section O, 12 of 13 (92%), individuals who were diagnosed and/or hospitalized with a PNM issue were assessed by the PNMT or IDT. There were still many instances, however, in which assessments were not updated when the need arose. Examples included: • As reported in Section M, the quarterly Comprehensive Nursing Assessments were not updated when there was a significant change in health status. • As reported in Section K, documentation provided during the current site visit revealed circumstances in which individuals living at DSSLC had experienced health problems involving cognitive and adaptive impairment, and for whom no routine or updated assessment of those abilities had been provided. <u>Quality and comprehensiveness of assessments</u> There were some improvements noted in some of the assessment processes at DSSLC. Examples include: • As described in Section L, there was evidence of significant improvement of medical assessments by the clinicians. In one sample of fifteen assessments, all (100%) appeared to be thorough. • As described in Section S, the Functional Skills Assessment (FSA) currently in use reflected advancement from the previous PALS assessment, although it still had significant limitations. • As reported in Provision J2, all individuals supported by psychiatry had comprehensive psychiatric evaluations in place, although (as described in Provision J6, they did not yet consistently include all requirements of Appendix B). • As reported in Provision K5, there had been significant improvement in the quality of functional assessments, with the need remaining to identify preferences and reinforcers through a formal reinforcer/preference assessment. • Assessments indicated whether or not the individual required OT/PT supports and services for 27 of 27 (100%) (Sample #1, #2, #3) records reviewed. • As reported in Provision M2, Sections I to IX of the Nursing Assessments showed	

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		some steady improvement in completing these section assessments with more substantive information in the summaries relative to the system assessed. Problems of quality and comprehensiveness still remained, as the following examples demonstrate: • As reported in Section R, communication assessments were not comprehensive enough to allow for the identification and potential expansion of communication skills, as they lacked identification of communications strengths, consistent functional programs, and strategies to enhance or facilitate communication. Another concern was that 12 assessments reviewed were generic in that they were identical with the exception of a few sentences, and the recommendations for these 12 assessments were also identical. This similarity in assessments and recommendations represents a lack of an individualized communication assessment. • As reported in Section O, only three of 27 Individuals (11%) were provided with a comprehensive assessment by the Physical and Nutritional Management (PNM) team and/or IDT 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. • Although 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. • Based on a review of 27 individuals' (sample #1, #2 and #3) most recent OT/PT assessments, three of 27 Individuals (11%) were provided with a comprehensive assessment by the PNM team and/or IDT that focused on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, and 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. • The OT/PT assessment addressed general aspects of 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 • Although annual medical assessments were thorough, assessments for some individuals with specific conditions did not show evidence of all recommended or required studies or specific plans to address the conditions. For an individual with Down syndrome, assessments lacked some necessary studies and also	

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		plans specific to Down syndrome. For an individual with PKU, the assessment did not include comprehensive plans to address PKU. • Although there was much improvement in Sections I-IX of the Nursing assessments, only one of 17 (6%) adequately summarized each identified nursing problem and stated the individual's health status progress and the effectiveness of the Health Maintenance Plan (HMP). As reported in Provision P1, an additional concern was that there was no discussion of potential for skill acquisition in areas such as eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning. Provision P1 also noted that a new format was in draft status for OT/PT evaluations. Based upon review of the assessment, the format and guidelines appeared to direct staff in providing a comprehensive assessment. Whether or not the revised assessment (3/23/12) will result in more comprehensive assessments will need to be reviewed at the next compliance review. <u>Conclusion</u> Although there had been improvements in both timeliness and quality of some assessments, a great deal more progress must be made in order to comply with the requirements of this provision.	
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. However, there were issues related to the other requirement of this provision, that diagnoses clinically fit corresponding assessments or evaluations. For psychiatric diagnoses, the most common problems were instances where the psychiatrist stated that the various symptoms met criteria for Axis 1 and Axis II diagnoses, but did not specify how. Sometimes it was possible for the Monitoring Team to deduce how the individual met the needed diagnostic criteria, but not always. The second common problem was the case where the psychiatrist noted symptoms that were consistent with a diagnosis, but were not sufficient to make that diagnosis. Examples may be found in Provision J6. 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 relevant to certain specific conditions but were not ordered.	Noncompliance

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		Conclusion Although this provision is not yet in substantial compliance, continued improvement in documenting the rationales for psychiatric diagnoses, and continued improvement in assertive follow-up assessments to resolution of acute conditions and care of chronic conditions should result in substantial compliance.	
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. One process has potential to identify the need for changes in interventions; a quarterly chronic care quarterly visit that requires documentation in a number of areas provides a means to identify changes in status that might have occurred and to initiate changes in care, but the Facility did not provide information that indicated it tracked the outcomes of these visits. The report from the last compliance visit noted that the incidence of pneumonia at the Facility indicates the possibility that treatments and interventions to prevent pneumonia were not timely and appropriate. The self-assessment noted reduction in pneumonia and aspiration pneumonia. The Monitoring Team expects that the Facility will continue to review these data to see whether this decline continues and also to see whether additional actions taken are effective in further reducing incidence of pneumonia. As reported in Provision H4, the Facility had identified an initial list of clinical indicators of health status and had data over a year for some indicators; these could also provide indications of whether interventions are timely and clinically appropriate. As noted in Provision K3, the peer review process was effective in improving the PBSPs. Nevertheless, there were still some area in which interventions were not timely, as the following examples document: • Communication assessments for Individuals #11, #707, and #347 recommended an Environmental control (EC) objective but there was no evidence that these objectives were written. • Individual #777 had a communication goal that focused on her responding to the question "Do you want to sit in your recliner?" by activating an AAC device. Per review of the assessment, it stated that receptively, the individual was unable to comprehend this complex of a request; therefore the goal was not based on the findings of the assessment. • Individual #50 experienced an increase in insomnia in July 2011 that continued for several months. Verbally disruptive behavior, as well as aggression against people and property, increased in October of 2011 and remained elevated for several months. Neither progress notes nor treatment documentation reflected any attempt to revise the PBSP or psychotropic medication regimen during the	Noncompliance

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		noted increases in behaviors and symptoms. • As reported in Provision L1, Individual #637 had an abnormal red blood cell finding, macrocytosis, which should be assessed. There was no diagnosis of macrocytosis, nor follow-up of this condition noted in the records. • 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. 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. <u>Conclusion</u> The Facility has made strides toward the ability to ensure that medical treatments and interventions are implemented timely through the use of clinical indicators and the chronic care quarterly visits. No development of similar actions for other clinical areas was reported to or noted by the Monitoring Team. This progress in developing such monitoring should expand to all areas of clinical care to ensure interventions are timely and appropriate based on assessments. 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.	The Facility had developed a set of clinical indicators that could be used to assess efficacy of treatments and interventions. The databases permitted these indicators to be tracked and reported facility-wide, by units, and by individuals. Thus, the information could provide excellent data to evaluate the effects of systemic changes in services as well as to assist clinicians to assess the progress or decline of specific individuals on health conditions. Clinical indicators being monitored at the time of the compliance visit were: • Emergency Room (ER) Visits • Infections • Hospitalizations • Deaths • Pneumonia • Aspiration pneumonia • Enteral feeding • Injuries • Decubitus • Diabetes • Risks The databases for these items were populated with information that was already	Noncompliance

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		available, so that some categories had data available for several years. The Facility provided graphs of deaths beginning 2009, all pneumonia beginning 2010, decubitus beginning 2010, hypoglycemia and hyperglycemia incidence beginning 3/11, ER visits beginning 2/11, infections beginning 1/11, and hospitalizations beginning 2010. The Facility provided a larger list of indicators along with the reviewing authority (such as PNMC, IMRT, Infection Control Committee, and Dental Workgroup); this had a column for "Frequency" and appeared to be a work in progress. Establishing the reviewing authority and frequency of reviews would be a valuable process and could be a step in determining which clinical indicators would be key indicators for Facility-wide QA/QI Council review and improvement/corrective action planning. The Facility provided information on one initiative that had already begun using these data to identify actions needed. Since September, 2011, the trending of hypoglycemic and hyperglycemic episodes was added to the summary section of the Monthly Diabetic Tracking Spreadsheet. With the use of the monthly summary the IDTs were able to quickly assess the effectiveness/progress (or lack of) resulting from any adjustments made to individuals' medical or dietary regiments. It was reported that IDTs, as well as the consulting endocrinologists, found the modification to the monthly summary reports useful. The Diabetic Management Review, 4/3/12, described the rationale for selecting hypoglycemia and hyperglycemia indicators to study and measure the success of diabetic management. The methodology used for the study included: Monthly, each individual was evaluated for the incidence and timing of low blood sugars (<70 mg/dL) and high blood sugars (>300 mg/dL) readings. Most of the individuals who were identified at the highest risk for hypoglycemia and/or hyperglycemia included routine administration of insulin. Therefore, all individuals who received insulin routinely were included in this initial study of hypoglycemia and/or hyperglycemia events. The monthly totals for the past twelve months were recorded and graphed. The results of the study found significant improvement in the incidence of hypoglycemia and hyperglycemia in more than half of the individuals in the study. Other areas of progress in developing and using clinical indicators were evident. • DSSLC demonstrated notable progress in relation to ensuring that behavioral treatment data were reviewed at least monthly. In addition, this review process was facilitated by the inclusion of criteria to guide the review process. All of the PBSPs that were reviewed during the site visit included specific and measurable criteria for treatment success, including timeframes within which treatment benefits were expected. In addition, Although this process was in place, only 38% of PBSPs either showed progress or were revised. It was reported,	

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		however, that substantial changes had been recently introduced to the data presentation and progress note format. These improvements included changes to the graphing process, increased use of phase-change lines and annotations, and the integration of psychiatric target symptom tracking. The Facility reported that the intent of the changes was to improve the ability to assess the response to treatment. However, gaps in identification, documenting, and using clinical indicators remained. • As reported in Provision O7, while PNMPs were reviewed at the ISP, 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). However, as reported in Provision O1, PNMC minutes referenced the clinical indicators being developed by the Facility, including those reported above and also choking incidents, skin integrity, fractures, falls, and others relevant to PNM issues and care. • In the cases in which physical and occupational therapy supports had been provided, there was no assessment as to the effectiveness of the interventions as evidenced by lack of identification of clinical indicators. • The Facility had yet to develop core indicators to assess clinical outcomes of dental services. <u>Conclusion</u> The Facility had made significant progress in developing clinical indicators and in beginning to use them for decision-making. This development process is continuing. A critical issue will be whether this information is used by clinicians and the IDTs in identifying the need for individual re-assessments and revisions in supports and services, and by the Facility in identifying and prioritizing systemic improvements to be made and in evaluating the effectiveness of actions.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	The Facility reported several systems had been established to monitor the health status of individuals. These included: • The development of clinical indicators, as reported above in Provision H4 • The chronic care quarterly visit process • The establishment of a Physical and Nutritional Management Team (PNMT) that follows individuals. In addition, the Monitoring Team notes the Risk Level assessment and monitoring process and also that the SA requires monthly reviews by the appropriate IDT member	Noncompliance

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		and quarterly reviews by the QDDP. The risk assessment process, as reported in Section I, had improved particularly for PNM issues. However, as noted in Section I and other sections of this report, there were still concerns about accuracy of assessing risk. This process will need to show continuing improvement. Clinical indicator data might provide information that will help improve accuracy of risk assessment. Although the Facility has populated the data set for many items, the system is too new to have allowed decision-making based on the broad range of indicators. As noted in several sections, lack of progress or change in status that should have been identified in a monthly review by a clinician was not always identified, or there was no evidence of review. For example: • Individuals #691 and #175 had AAC objectives but there was no evidence of monthly or quarterly review by the SLP or QMRP. • Individual #50 experienced an increase in insomnia in July 2011 that continued for several months without any documentation of consideration of revisions to supports and services. Furthermore, review of progress of change in status was hampered in some cases by the lack of definition of goals and objectives or objective data to be reported, or by missing data. For example: • HMPs were generic and not individualized to meet individuals' specific needs, and only slightly more than half had adequate goals stated to measure the desired outcomes. • There was a lack of consistent completion of aspiration trigger sheets. Nevertheless, the Facility should be complimented on the progress made to date. For example, the PNMT had met 24 times by 2/29/12 and provided an opportunity to track high-risk individuals carefully. In addition, the development of a sophisticated and comprehensive set of clinical indicators, with the ability to break out the data to the level of individuals served, has to potential not only to make information about status and progress easily accessible to clinicians but also to make possible the development of "red flag" alerts when there is a change in status that requires attention. The Facility must ensure not only that these processes are implemented and information is available, but also that monitoring leads to decisions that improve care, supports, services, and the well-being of the individuals served.	

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		Conclusion The Facility had established several processes to monitor health status of individuals. The processes for the PNMT and clinical indicators had not yet been completely developed, all processes had not yet been put together into a cohesive system, and they had not yet had widespread effects on decisions. If the systems are maintained and used thoughtfully, they could provide the basis for a finding of compliance.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	This section will require demonstration of a functional system that is both integrated and ensures all clinical services make decisions on treatments and interventions timely in response to clinical indicators. The development of clinical indicators at the Facility level could provide a means to identify when modifications are needed and to give clinicians objective and useful information. The various protocols developed by the State Office represent an initial framework, but there needs to be evidence these are put into action, support and are supported by appropriate clinical indicators, and lead to treatment that reflects that interventions and changes in interventions are based on identified clinical indicators and criteria that are appropriate for the individual. There were examples in which this had begun to occur, such as this: • PNMPS were reviewed by the IDT and consistently updated in a timely manner by Habilitation Therapies as indicated by a change in the person's status. In 11 of 11 records reviewed (100%) (Sample #2), PNMPs were revised in a timely manner as indicated by a change in the individual's status. On the other hand, there remained many examples in which revisions did not occur timely in response to clinical indicators. • As reported in Provision K4, of 8 PBSPs reviewed, only three (38%) reflected either appropriate revisions following increases in treatment targets or an adequate response to treatment that negated the need for any revision. For the remaining 5 PBSPs (62%), poor treatment response did not result in a change in the PBSP. • As reported in Provision K10, although DSSLC had greatly improved the quality of the data graphs, it was not evident that these data graphs were consistently and effectively used to formulate treatment decisions. In only three of the eight records included in the sample, were decisions to either continue or revise PBSPs and psychotropic drug interventions supported by the available data. In the majority of records, the progress notes and data indicated that no review or revision of the PBSP had been conducted despite indications that the current	Noncompliance

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		interventions were ineffective. Furthermore, several records reflected that individuals experienced increases in problem behaviors or indicators of mental illness for several months without a response from the IDT. • As reported in Provision P1, in In many cases involving physical and occupational therapy services, clinical information was merely reported, but was not utilized to guide decisions regarding intervention. o There was no comparative analysis of health and functional status from the previous year. In the cases in which therapy supports had been provided, there was no assessment as to the effectiveness of the interventions as evidenced by lack of identification of clinical indicators. o 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. <u>Conclusion</u> As noted above, the development of clinical indicators, the implementation of the PNMT, the chronic care quarterly visits, and other processes established in recent months provide the basis for modifying treatment based on clinical indicators. That was not yet the consistent practice. The Monitoring Team will review to see whether the potential inherent in these processes will be fulfilled, which will require clinicians and IDTs to monitor the information and take assertive action as needed. The Facility will need to develop means not only to ensure the information is available and the processes are in place, but also that they are effective in ensuring appropriate modifications are made.	
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	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. DSSLC had implemented DSSLC Policy CMGMT 03 Integration of Clinical Services 3/27/12. This recently implemented policy listed numerous areas in which integrated discussion and action should occur, and which disciplines should participate. These ranged from committees to dental/medical treatment to who documents in Integrated Progress Notes to a master schedule. However, this policy provides few expectations or procedures for how clinical services should be integrated and does not address the provisions of Section H. Facility policy should be developed to address these provisions and should be consistent with the new policy on Integration of Clinical Services.	Noncompliance

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

1. Review the processes to track assessments, diagnoses, and diagnostic updates to ensure assessments and evaluations are done regularly as required by policy and in response to changes in an individual's status. Where tracking indicates assessments and evaluations are not completed timely, the Facility must develop systemic improvement actions to improve timeliness. (Provision H1)
2. Monitoring systems such as the chronic care quarterly visits and tracking of outcomes through clinical indicators should expand to all areas of clinical care to ensure interventions are timely and appropriate based on assessments. The Facility should use the peer review processes that address other Sections of the SA to ensure treatments are clinically appropriate. (Provision H3)
3. The Facility will need to develop means not only to ensure the information from clinical indicators is available and other monitoring processes are in place, but also that they are effective in ensuring appropriate modifications are made. (Provision H6)
4. Facility policy should be developed to address the provisions of this Section and should be consistent with the new policy on Integration of Clinical Services. (Provision H7)

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 Self-Assessment 3/16/12 2. DSSLC Action Plan 3/8/12 3. Section I Presentation Book (undated) 4. DADS Policy 006.1 At Risk Individuals (2/18/11) 5. DSSLC Policy CMGMT -14 At Risk Individuals 1/1/11 6. Physical/Nutrition Management Committee (PNMC)meeting minutes October, 2011 through March, 2012 7. List of Health Risk Ratings for each risk factor/individual (undated) 8. Staff training rosters October, 2011 through March, 2012 9. Record reviews for Individuals #1, #13, #42, #53, #64, #119, #131, #134, #165, #255, #331, #336, #337, #392, #394, #519, #534, #537, and #587 10. Integrated Risk Rating Form and Risk Action Plan for Individuals #13, #42, #64, #131, #165, #331, #336, #337, #392, #394, #519, #537, and # 587 (sample selected for data analysis) 11. Other Integrated Risk Rating Forms and Risk Action Plans: Individuals #68, #114, #129, #165, #177, #183, #255, #272, #331, #226, and #392 12. Provision O – Sample #2 13. List of Top 10 individuals causing injury to peers 14. List of Top 10 injured individuals. 15. List of individuals supported with bedrails 16. List of individuals injured from bedrails **People Interviewed:** 1. Nancy Condon, Facility Director 2. Donna Groves, OTR, Director of Habilitation Services 3. Joy Sibley SLP, Director of Communication Therapy 4. Randy Spence, M.S., Director of Behavioral Services 5. Delia Schilder RN, Chief Nurse Executive 6. Sibylle Graviett, RN-Case Manager Supervisor 7. Sherri Courtney, RN, Nursing Operations Officer **Meetings Attended/Observations:** 1. Physical/Nutrition Management Committee (PNMC) 4/5/12 2. ISP meeting for Individuals #1, #53, and #464
	Facility Self-Assessment: The Facility's self-assessment reported the DSSLC was not in substantial compliance with any Provision of this section of the Settlement Agreement (SA). The self-assessment included a review of policy, a review of data generated from monitoring tools, a case sample examined separate from cases monitored using the monitoring tool, and discussion topics of the Physical and Nutritional Management Committee. Based on the findings from its self-assessment, the Facility determined that it was not in substantial

	compliance because there was apparent underrating of individuals on their risks and that IDTs are failing to implement risk reassessment in a timely manner. The Facility reported that actions to increase data collected and address inter-rater reliability will not be evident until the next review. The Facility also reported that additional work was also needed to improve development and implementation of Risk Action Plans by interdisciplinary teams. The Monitoring Team's review substantiated this self-assessment.
	Summary of Monitor's Assessment: The statewide risk assessment policy, with guidelines for rating risk, was in use at the Facility. The Facility had created supplementary tools that IDTs could use in the risk assessment planning process. For example, the Facility had created a resource guide titled "Action Plan Considerations" that identified, for each risk category, a number of action steps that could be considered when an individual was determined to be at medium or high risk. The Facility had a very active Physical and Nutritional Management Committee. This group met at least monthly and was chaired by the Facility Director. It was evident to the Monitoring Team that the membership make-up of this committee contributed to substantive discussion and decision-making. It was also evident that committee members were the key players needed to effectively implement the policies and procedures necessary to achieve compliance with this Provision of the SA. The Monitoring Team is optimistic that the work of this committee will lead to significant improvement in risk assessment at the next review. The Monitoring Team observed three ISP meetings held during the week of the review. It did not appear that all staff needed to participate in a risk assessment discussion at the ISP meetings were in attendance. None of the IDTs engaged in substantive discussion on how risk impacted potential alternative placement. The risk assessment process in place at the Facility did not always accurately assess risk; however, the Monitoring Team noted improvement in the risk assessment process for physical nutritional management issues. Few risk ratings adequately rated the individuals on all risk categories based on supporting clinical data. Integrated Risk Ratings varied in the quality of substantive clinical data to support the various risk ratings, over time and with the different IDTs. Risk categories were not consistently rated accurately according to the Risk Guidelines and/or the individuals' heath status based on medical history, treatment regimens, and other supporting clinical data that was noted. The Monitoring Team identified four risk action plans that were sufficient in scope and depth that if followed would likely be effective in managing or mitigating risk.

#	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.	Facility Self-Assessment: The Facility engaged in the following activities in conducting its self-assessment of this Provision: • Review of policy to see if it included information required by the settlement agreement. • Review of overall risk data by home and compare to home population rosters to determine if all individuals have had a risk assessment completed. • Review of specific high risk categories and comparison with other clinical data to determine if the numbers of those at high risk correlate with other data. • Review of Monitoring for Section I to determine current monthly compliance percentages. • Selection and review of additional sample for self-assessment purposes. The Facility's self-assessment reported the following: • The policy included a risk screening, assessment and management system. • All individuals currently had risk ratings completed by their interdisciplinary teams including the person most recently admitted to the center. • A list of those at high and medium risk was pulled for Aspiration, Choking, Respiratory Compromise and Challenging Behavior. Review of these lists indicated apparent variation in ratings of individuals. Only one individual that had a choking incident during the last five months was identified as high risk for choking. The lists for risk of aspiration appeared to be more accurate but under-rating is still suspected. A sample of those with incidents of aspiration during 2011 was reviewed and all but one or 94.2% were on the list. • Section I monitoring data revealed too few data tools being collected for an accurate comparison. Current data indicated 0% success in January and a subsequent downward trend in success over the time period in this area. Data varied between 0 and 100%. • Due to the small number of tools used and the variation, an additional sample of risk documentation for those with changes in status was pulled. This data showed an overall success of 78.57% for this audit. 100% of those pulled, however, had taken action to reduce risks. Based on the findings from this self-assessment, the Facility determined that this provision was not in substantial compliance because there is still apparent underrating of individuals on their risks. Actions to increase data collected and address inter-rater reliability will not be evident until the next review. Additional work is also needed to improve implementation by interdisciplinary teams as well.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Monitoring Team Findings: The statewide risk assessment policy, with guidelines for rating risk, was in use at the Facility. The Facility had created supplementary tools that IDTs could use in the risk assessment planning process. For example, the Facility had created a resource guide titled "Action Plan Considerations" that identified, for each risk category, a number of action steps that could be considered when an Individual was determined to be at medium or high risk. The Facility had a very active Physical and Nutritional Management Committee. This group met at least monthly and was chaired by the Facility Director who is also the section lead for Section I. The Monitoring Team observed one meeting. The agenda for the meeting was comprehensive covering many elements of policy implementation, staff training needs, and/or policy clarifications. The committee membership included, among others, the Medical Director, Habilitation Therapy Director, Chief Nurse Executive, Nursing Operations Officer, Director of Residential Services, and the Assistant Director of Programs. It was evident to the Monitoring Team that the make-up of the committee contributed to substantive discussion and decision-making. It was also evident that committee members were the key players needed to effectively implement the policies and procedures necessary to achieve compliance with this Provision of the SA. The Monitoring Team is optimistic that the work of this committee will lead to significant improvement in risk assessment at the next review. The Monitoring Team observed three ISP meetings held during the week of the review. Staff present at the ISPs was the actual staff who worked with the individual; although it appeared not all staff needed at the ISP meeting were in attendance. For example, the ISP meeting for Individual #53 included a discussion of preferences. This discussion would have been more productive if a Direct Care Professional (DCP) from the afternoon shift was present. The ISP meeting for Individual #1 did not include an occupational therapist and this individual had related service needs. The DCP missed most of the meeting and the psychologist was in and out of the meeting. The individual was present at both meetings. The IDT used the Risk Level Guidelines established in State policy for assessing and determining risk levels. The ISP meetings observed by the Monitoring Team included open discussion among IDT members; however, the scope and depth of these discussions was somewhat diminished because of the attendance issues described in the previous paragraph. None of the IDTs engaged in substantive discussion on how risk impacted potential alternative placement.	

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		In two meetings the ISP facilitator kept the team discussion focused. One meeting (Individual #1) was less focused primarily because of the attendance issues described in the previous paragraph. The risk assessment process in place at the Facility did not always accurately assess risk. For example, based on a review of 11 (Section O - Sample #2) records of individuals who experienced an aspiration or choking event, five of 11 (45%) records reviewed accurately identified individuals who were at an increased risk of physical and/or nutritional decline. This determination is consistent with the conclusions noted in the Facility's self-assessment. The self-assessment noted that only one individual that had a choking incident during the last five months was identified as high risk for choking. Examples of individuals not being appropriately identified included: • Individuals #42 and #119 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. • Individuals #255 and #534 were identified as being at a "medium risk" of choking but per guidelines should have been listed as a "high risk" due to recent choking events.	
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.	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision: • Review of Denton State Supported Living Center monitoring tool data for Section I.2. • Selection and review of additional sample for self-assessment purposes. The Facility's self-assessment reported that Section I monitoring for Provision I.2 indicated that: • The data in January showed this area to be at 0% compliance. Section I monitoring data revealed too few data tools being collected for an accurate comparison. While there is improvement noted the low amount of data since November and the extreme variation in results make the data suspect. • Due to the small number of tools used and the variation, an additional sample of risk documentation for those with changes in status was pulled. This data showed that for 100% of those sampled that the interdisciplinary team assessed the person; however, only 67% of those sampled began within five days of the change in status.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Based on the findings from this self-assessment, the Facility determined that this provision was not in substantial compliance because significant variances in monitoring data and lack of inter-rater reliability occurred particularly from November 2011 – January 2012. Actions to increase data collected and address inter-rater reliability will not be evident until the next compliance visit. Additional review of records indicated that IDTs are failing to implement reassessment within 5 working days of a status change 33% of the time. <u>Monitoring Team Findings:</u> The Monitoring Team selected 13 records to review to assess compliance with this provision. These were for Individuals #13, #42, #64, #131, #165, #331, #336, #337, #392, #394, #519, #537, and # 587. The most recent risk assessment for these 13 individuals reported a change in status in four cases. These were for Individuals # 13, #42, #394, and #519. In each of these four the assessment process started within five days. In the other nine cases a comprehensive assessment that could have determined whether or not a change in status was appropriate only occurred with one individual. This was the case with Individual #392. The records of these 13 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 IDT must start an assessment process as soon as possible but within five working days of the individual changes. The Facility's self-assessment reported this requirement was met in only 33% of the records reviewed. In the Monitoring Team's sample, an at-risk condition for four individuals had changed. This was the case for Individuals #13, #42, #394, and #519. Nine records (69%) did not contain documentation that changes in circumstance should have resulted in changes to an at-risk assessment, rating, or plan. This was the case for Individuals #64, #131, #165, #331, #336, #337, #392, #537, and #587. This finding by the Monitoring Team was reasonably consistent with the data presented in the Facility self-assessment. Based on a review of records of a sample of three individuals (Individuals #331, #336, and #392) for whom assessments had been completed to address the individuals' at risk conditions, one (33%) included an adequate nursing assessment to assist the team in developing an appropriate plan. This was the case for Individual #392. The following provides an example of an assessment that was not comprehensive: the assessment for Individual #336 noted high risk for osteoporosis but the Risk Action Plan and ISP did not include clinical indicators to be monitored, except to monitor osteoporosis medication that the individual was not receiving. There was no documentation to suggest that in the development of the Risk Action Plan that consideration of clinical indicators was	

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		reviewed. Based on a review of records of a sample of four individuals (Individuals #13, #42, #394, and #519) for whom assessments had been completed to address the individuals' at risk conditions, all (100%) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in developing an appropriate plan. Based on a review of records of six individuals (Individuals #64, #131, #165, #337, #537 and #587) with challenging behavior and/or polypharmacy 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 noted improvement in the risk assessment process for physical nutritional management issues. For example, twelve of 13 (92%) individuals who were diagnosed and/or hospitalized with a Physical Nutritional Management (PNM) issue (data from Provision O -Sample #2) were assessed by the Physical Nutritional Management Team (PNMT) or IDT. Examples of assessment follow-up include: • Individual #534 had a choking event on 9/2/11. On 9/16/11, the Occupational Therapy Aide and Occupational Therapist conducted observations and provided recommendations to mitigate risk. A swallow study was also ordered to provide a more formal assessment of the swallow structure and functioning. • Individual #519 was diagnosed with aspiration pneumonia on 11/9/11. There was evidence of the IDT and PNMT meeting to discuss the event and focus on potential indicators or triggers that led to the aspiration event. As a result of the meeting, the individual's positioning plan was revised. • Individuals who have returned from the hospital with a PNM related diagnosis were reviewed by the PNMT. The level of oversight by the PNMT was divided into four categories (Full Assistance, Consultation, Monitor for change, and Watchful Eye). An issue noted with this process was that while the levels identified the role of the PNMT in each level, there was not a defined criterion that guided the PNMT in determining who belonged in what level. Lack of criteria decreased the likelihood that individuals would receive a comprehensive PNM evaluation. For example, Individual #134 had multiple pneumonias over the past quarter but was listed as a level three which means that the PNMT would not need to look at the individuals for six months. • The PNMT Nurse was also responsible for assessing each individual who returned from the hospital with a PNM related issue. The concern noted by the Monitoring Team was that there was not a clear connection between the PNMT	

#	Provision	Assessment of Status	Compliance
		Nurse assessment and how it guided decision-making in better identifying who should be referred to the PNMT. In its current format, the assessment consisted of a progress note that focused on current vital signs and status but did not aid in detecting the need for a PNM assessment by asking specific questions regarding changes in PNM status. In the nursing area issues were identified in the risk assessment and action plan process. These are described fully in Provision M.5 and include: • One of eight (13%) Integrated Risk Ratings adequately rated the individuals on all risk categories based on the supporting clinical data included in the rationale column. • Five of eight (63%) included BRADEN scores for skin integrity rating. A review of the individuals' Integrated Risk Ratings varied in the quality of substantive clinical data to support the various risk ratings, over time and with the different IDTs. Risk categories were not consistently rated accurately according to the Risk Guidelines and/or the individuals' heath status based on medical history, treatment regimens, and other supporting clinical data that was noted in the rationale, nor was clinical data included that should have been to make sound judgments related to the specific risk rating categories. It did not appear that all relevant clinical disciplines contributed substantive clinical data for their respective areas of expertise. Multiple examples are provided in Provision M.5. As noted in Provision M.5, none of six (0%) Risk Action Plans were adequate to meet all of the individuals' high and medium risk ratings. The Risk Action Plans did not consistently include plans for all identified high and medium risk ratings. The plans contained some basic action steps to address the high and medium risk ratings, but failed to include all relevant action steps to adequately address the risk ratings, nor were all relevant disciplines included in the action steps. For individuals with high and medium risk ratings who should have had nursing Health Maintenance Plans, these were rarely referred to in the plans, nor were other relevant disciplines' plans referred to. Therefore, the Risk Action Plans were not adequately integrated. Multiple examples are provided in Provision M.5.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for	<u>Facility Self-Assessment:</u> The Facility engaged in the following activities in conducting its self-assessment of this Provision: • Review of Denton State Supported Living Center Monitoring/Tool data for provision I.3. • Selection and review of additional sample for self-assessment purposes.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	The Facility's self-assessment for Provision I.3 reported the following: • The data in January showed this area to be at 0% compliance. Section I monitoring data revealed too few data tools being collected since November for an accurate comparison. The low amount of data since November and the extreme variation in results make the data suspect. • Due to the small number of tools used and the variation, an additional sample of risk documentation for those with changes in status was pulled. This data showed the following: o Actions developed by the team -100% compliance o Actions implemented within 14 days of plans finalization – 83% compliance. o Actions include clinical indicators to be monitored – 50% compliance. o Actions include frequency of monitoring – 67% compliance. Based on the findings from this self-assessment, the Facility determined that this provision is not in substantial compliance because significant variances in monitoring data and lack of inter-rater reliability occurred particularly from November 2011 – January 2012. Actions to increase data collected and address inter-rater reliability will not be evident until the next compliance visit. Additional review of records indicated that improvement is needed in implementation of actions, including clinical indicators and frequency of monitoring. <u>Monitoring Team Findings:</u> Based on a review of 13 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 nine (64%)) cases. Records that did not contain documentation of this included Individuals #64, #131, #165, and #537. • Implemented a plan that met the needs identified by the IDT assessment in five (38%) cases. Records that did not contain documentation of this included Individuals #64, #131, #165, #331, #337, #392, #537, and #587. • Included preventative interventions in the plan to minimize the condition of risk in eight (62%) cases. Records that did not contain documentation of this included Individuals #64, #131, #165, #331, and #537. When the risk to the individual warranted (four cases), the Facility took immediate action in four (100%) cases. • Integrated the plans into the ISPs in eight (62%) cases. Records that did not contain documentation of this included Individuals #64, #131, #165, #331, and	

#	Provision	Assessment of Status	Compliance
		#537. • In seven (54%), 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 #64, #131, #165, #331, #392, and #537. • In one (8%), appropriate functional and measurable objectives were incorporated into the ISP to allow the team to measure the efficacy of the plan. This was the case with the plan for Individual #336. None included the clinical indicators to be monitored and the frequency of monitoring. The Monitoring Team identified four risk action plans that were sufficient in scope and depth that if followed would likely be effective in managing or mitigating risk. These were for Individuals #13, #42, #394, and #519. The At Risk Individuals Policy and instructions required the relevant disciplines to complete their risk assessments 10 days prior to the ISP date and make them available to the RN Case Managers to review in collaboration with the responsible physicians. Then, the RN Case Managers aggregate the assessment data into a draft Integrated Risk Rating Form to be used at the ISP meetings to review, discuss, and determine risk ratings. According to interviews with Nursing Administration and RN Case Managers, with possibly the exception of Habilitation Services, the disciplines did not provide their assessments within 10 days prior to the ISP meeting dates, if at all. Because the disciplines' risk assessments were not submitted timely to the RN Case Managers valuable assessment data may not be included, or may be overlooked, in the draft Integrated Risk Rating presented at the ISP. If this happens, it could result in inadequate and/or inaccurate risk ratings for the individuals. It is essential that each discipline responsible for their respective risk categories complete comprehensive risk assessments of individuals' overall health status though collaboration with other relevant disciplines, including interviews with the individuals' direct care professionals, and a thorough review of clinical records. The assessment should be completed at least 10 days prior to the ISP meeting dates and submitted to the respective RN Care Managers. The RN Case Managers should corroborate their risk assessment findings with respective physicians prior to the ISP meetings to ensure that all medical, mental and behavioral health related risk factors are identified; and the risk ratings are comprehensive, integrated, and accurate. Establishing a competent and reliable risk rating 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 Provisions M.2 and M.3 for additional information related to nursing assessments of risks and health care plans.	

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		The Facility should ensure that: • Each discipline responsible for their respective risk categories complete comprehensive risk assessments of individuals' overall health status through collaboration with other relevant disciplines, including interviews with the individuals' direct care professionals, and a thorough review of clinical records. The assessments should be completed at least 10 days prior to the ISP meeting date and submitted to the respective RN Case Managers. • The RN Case Managers corroborate their risk assessment findings with respective physicians prior to the ISP meetings to ensure that all medical, mental and behavioral health related risk factors are identified; and the risk ratings are comprehensive, integrated, and accurate.	

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

1. Assure all IDTs are provided with training and ongoing technical assistance on implementation of the At Risk policy and its incorporation into the ISP 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 ISP process. (Provisions I.2 and I.3)
3. Ensure that appropriate and timely assessments and revisions of the ISP are done for any individual whose level of risk is revised as the At-Risk Individuals policy is implemented. (Provision I.3)
4. Ensure discipline assessments are done timely and lead to integrated risk assessment determinations and integrated Risk Action Plans. (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 Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self Assessment (03/16/12) and Action Plans (03/08/12) 2. Facility Presentation Book for Section J (undated) 3. DADS Policy and Procedures 007.2 Psychiatry Services (08/30/11) 4. DADS Procedure 001 Use of Restraints (08/15/09) 5. DADS Nursing Protocol Post Anesthesia Care (06/2010) 6. DADS Nursing Protocol Pre-treatment and Post Sedation Monitoring (06/2010) 7. DSSLC Policy and Procedure CMGMT-21 on Dental and Medical Restraint (11/05/09) 8. DSSLC Procedure: Desensitization CMGMT 24 (12/15/11) 9. DSSLC Nursing Responsibility related to restraints (updated 02/16/12) 10. DSSLC Policy Med-10 Psychiatry Services (01/15/11) 11. DSSLC Protocol for Metabolic Syndrome 12. A list of all individuals who received psychiatric care, including the current psychiatric diagnoses, the name of the treating psychiatrist, the psychotropic medications given to the individual, and the date of the Appendix B psychiatric evaluation 13. A list of any individuals for whom the psychiatric diagnoses have been revised since the last compliance visit, 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) 14. Minutes of the Pharmacy and Therapeutics Committee (P&TC) and the Polypharmacy Review Committee (PRC), since the last compliance visit 15. A list of individuals prescribed intraclass polypharmacy and interclass polypharmacy, including the names of medications prescribed and each medication's start date 16. A tabulation that compared rates of Facility use of polypharmacy over the period from January 2010 until the present 17. A separate list of individuals for whom each of the following is prescribed: a. Anticonvulsant medications being used only for psychiatric indications b. Anticonvulsant medications being used only for neurological indications c. Anticonvulsant medications being used for both neurological and psychiatric indications d. Lithium e. Tricyclic antidepressants f. Trazodone g. Beta blockers being used as a psychotropic medication h. Clozaril/Clozapine i. Mellaril j. Reglan k. Anticholinergic medications l. Benzodiazepines 18. A list of individuals who had medical support plans and dental support plans to reduce the need for

	pre-treatment sedation 19. The number and percentage of individuals who had dental procedures, who also received pre-treatment sedation (oral or TIVA) 20. A list of all individuals screened for tardive dyskinesia with DISCUS evaluations 21. A list of all individuals screened with MOSES side effects evaluations 22. DISCUS forms done over the past year that were rated "5" or higher 23. A list of individuals diagnosed with tardive dyskinesia and the Active Problem Lists for each of those individuals 24. Reiss screens (both data and scoring sheets) done since the last review 25. A list of all individuals whose scores matched or exceeded Reiss Screen cut-off values per instrument guidelines 26. Sample J1: Individuals observed on 04/02/12 and 04/0312 during psychiatric clinics: These were Individuals #60, #183, #311, #321, #351, and #505 27. Sample J2: Case reviews for individuals that included all individuals admitted over the past six months, selected individuals who had Individual Support Plan (ISP) meetings after October 15th 2011, selected individuals assessed by the Facility as "best practice" cases for integrated behavioral healthcare, and individual assessed to be at risk based on polypharmacy and challenging behaviors. These were Individuals #151, #158, #228, #258, #269, #287, #482, #560, #732, #746, #781, #605, #612, #679, and #476. Materials reviewed were: a. Social History b. Most recent Psychiatric Evaluation (Appendix B format if done) c. Most recent Annual Psychiatric Review/ Annual Psychotropic Medication Review d. Most recent Positive Behavior Support Plan and Structural and Functional Behavioral Assessment (SFA) e. Most recent Personal Support Plan f. Most recent Annual Medical Summary g. Most recent Active Problem List h. All Psychiatric Medication Reviews for the past six months i. All MOSES/DISCUS Side Effects Screenings for the past six months j. All Quarterly Drug Regimen Reviews for the past six months k. Most recent Health Risk Assessment Rating – tool and team meeting sheet l. If the individual is assessed at high risk on the basis of polypharmacy or challenging behaviors –copies of the plan to reduce risk (ISP addenda) m. Medical and/or dental plans to increase cooperation/participation and reduce the need for pre-treatment sedation n. Most recent Annual Nursing Summary o. Most recent Neurology Consultation 28. Sample J3: Episodes of Medical Restraint: Each episode was reviewed for: (1): Safety during the procedure: Materials reviewed included medical orders; physician specified monitoring schedules, restraint checklists, pre and post sedation nursing checklists, integrated progress notes, (IPNs) and dental clinic notes that documented medical monitoring for safety during the procedures.

(2) Plans to minimize the need to use medical restraint: Materials reviewed included individual ISP and Individual Support Plan Addenda (ISPA) information regarding the need for pre-treatment sedation and the development and implementation of such plans, 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. Individual/episodes reviewed were

- Oral pre-treatment sedation for dental procedures: Individuals #228 (12/18/11), #332 (11/29/11), and #311 (11-06-11)
- Total Intravenous Anesthesia (TIVA) procedures for Individuals #209 (1/12/12), #506 (12/12/11), and #731 (12/14/11 and 2-13-11), and #772 (2/13/12)
- Oral pre-treatment sedation for medical procedures: Individuals #210, #360 #398, and #360

29. Documents related to psychiatric and neurological care for five individuals who took anticonvulsant medications for both neurological and psychiatric indications. Individuals #60, #277, #255, #319, #386 were reviewed. Materials were neurology clinic visit notes and other chart materials selected by the Facility to help the Monitoring Team understand the underlying neurological and psychiatric matters that were discussed.
30. Documents related to risk assessment for individuals assessed to be at high risk for injury due to challenging behavior and/or due to polypharmacy. Reviews were done for Individuals #165, #337, #537, #587, and #58. Materials reviewed included:
    a. The two most recent Risk Assessment Tools
    b. The individual's ISP prior to the most recent risk assessment and/or any ISP change of status documentation
    c. Documentation of assessments and other steps taken to develop an action plan to reduce the risk
    d. The action plan to address the risks (either ISPA or new ISP)
31. Psychotropic medications approved by the Behavior Support Review Committee (BSRC) and the Human Rights Committee (HRC) during the last six months. The following plans were reviewed Individual #34 (Abilify), #108 (Cymbalta), #158 (Remeron), #171 (Zyprexa), #194 (Prozac), #240 (Saphris), #247 (Trazodone), #306 (Cogentin), #397 (Lexapro), #451 (Depakote), #489 (Ativan), #545 (Cogentin), #572, (Inderal), #606 (Luvox), #642 (Risperdal), #659 (Lunesta), #704 (Doxepin), #732 (Seroquel), #799 (Abilify). Materials reviewed included:
    a. Information from the clinical record (e.g. progress notes, psychiatric treatment reviews, ISPAs) that will help the Monitoring Team understand the reasons/clinical rationales for choice of the medication
    b. IPNs, PTRs and other psychiatric notes that clarified the reasons the new medications were proposed.
    c. Consent for use of the Psychotropic Medication
    d. Revised Positive Behavior Support Plan (PBSP)

People Interviewed:

1. Ranganath Habbu, MD, Staff Psychiatrist
2. Robert Harden, MD, Contract Psychiatrist
3. Arifa Salam, MD, Lead Psychiatrist
4. Satyajit Satpathy, MD, Staff Psychiatrist

	5. Randy Spence, BCBA, Director of Behavioral Services 5. Jill Wooten, BCBA, SA Section C Lead 6. Delia Schilder, RN, Chief Nurse Executive (CNE) 7. Sibylle Graviett,, RN, Nurse Case Manager Supervisor 8. George Zukotynski, State Office Behavioral Services Coordinator 9. Ms. Karen Bishop, Desensitization Psychology Assistant **Meeting Attended/Observations:** 1. Psychiatric Medication Review (PMR) clinic with Dr. Salam, April 2,2012 2. PMR clinic with Dr. Habbu, April 2, 2012 3. PMR clinic with Dr. Satpathy, April 3, 2012 4. PMR clinic with Dr. Harden. April 3, 2012 5. Polypharmacy Review Committee April 3, 2012 6. Meeting on 04/02 with Ms. Wooten, Ms. Karen Bishop, and Dr. George Zukotynski, regarding medical restraints 7. Meeting on 04/02 with Dr. Zukotynski, Dr. Salam and Mr. Spence regarding psychology and psychiatry coordination 8. Meetings on 04/03 and 04/03 with Ms. Wooten, Ms. Schilder, Ms. Graviett,, Mr. Horstmann, and Ms. Courtney regarding medical restraints 9. ISP Annual Planning Meeting for Individual #53
	Facility Self-Assessment DSSLC had made considerable revisions to its self- assessment, previously called the POI. In the new format, the Facility described, for each provision item, the activities the Facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance, along with a rationale. That was an improvement in the Facility self- assessment activity. The Lead Psychiatrist authored the psychiatry section of the self-assessment, and a member of the Monitoring Team reviewed the self- assessment with her. The Psychiatry Department used several methodologies to compile the self-assessment. First, the department maintained spreadsheets with information on individuals who received psychiatric care. Information items tracked on these spreadsheets included the clinical diagnoses provided by the treating psychiatrist for each individual. Information tracked also included the dates of completion of MOSES and DISCUS side effect screens and Reiss Screen information. The spreadsheets helped provide information on self- assessment for provision items J5 and J12. Second, the department selected a sample of 20 records for review. Documents reviewed included Positive Behavior Support Plans, Psychiatric Evaluations and Annual Psychiatric Summaries, Psychotropic Medication Plans, and information about psychiatric symptom tracking. The Facility did not provide information on how the selection of the records to be reviewed was made, and did not mention how many reviewers were involved in the record review process. It would have been helpful for that information to

	have been included. Results of the record reviews were used to support the self-assessment for Provisions J8, J9, and J10. Third, for some provision items the self-assessment was based on a comprehensive review of documents that were the focus of that provision item. Accordingly, all new psychiatric evaluations (along with an unspecified number of annual psychiatric summaries) were reviewed for Provision J2, all new medication plans were reviewed for Provision J14 (informed consent), and minutes of each monthly meeting of the PRC were reviewed to self-assess compliance with Provision J11. For twelve provisions, the Facility's self-ratings were the same as those of the Monitoring Team. The exceptions were Provisions, J6, J7, and J10. For these provisions the Facility self-rated for substantial compliance, but the Monitoring Team found that additional progress is needed.
	Summary of Monitor's Assessment: The Facility continued to make progress in many areas. Positive practices noted were in the area of integrated care, as a result of the introduction of combined case formulations that clarified how learned behaviors and psychopathology each contributed to individuals' behavioral profiles. There were also improvements in the way that psychiatric data was reported, although the process by which psychiatrists and psychologists identified what should be tracked needed further attention. Progress in reducing unnecessary polypharmacy was impressive. However, Facility efforts to develop behavioral plans to minimize the need to use pre-treatment sedation remained at an early stage and continued attention to that area is needed. Also, attention is needed to the areas of justification of diagnoses, and to the development of the system for tracking and reporting psychiatric data. Comments on specific provisions follow: **For Provision J1:** The provision remained in substantial compliance: One of the three full time psychiatrists left the Facility and a new psychiatrist took his place. The Facility continued to employ three full time staff psychiatrists and one part time contract psychiatrist. All were board certified in psychiatry and all had sufficient experience with intellectual disabilities. The psychiatrists actively and appropriately participated in the interdisciplinary process. **For Provision J2**: The provision remained in substantial compliance. Procedures were in place to conduct evaluations and diagnoses prior to the administration of psychotropic medications. **For Provision J3:** The provision was determined to be not in compliance. Improvements were noted in the way treatment programs were described in PBSPs. These helped provide evidence that medications were not used as a substitute for a treatment program. However, the improvements were newly in place and had been implemented in only a small number of cases. **For Provision J4:** The provision was determined to be not in compliance. The process for developing plans to minimize the need for medical restraints remained at an early stage.

	For Provision J5: The provision remained in substantial compliance. Psychiatrists at the Facility had heavy clinical caseloads, but they were able to provide the services required by the SA. **For Provision J6:** The provision was determined to be not in compliance. Improvement was noted in the way psychiatric diagnoses were substantiated and target symptoms for treatment were identified, but further improvement in these areas was needed. **For Provision J7:** The provision was determined to be not in substantial compliance. Reiss screens had been administered across the campus, but the Facility had not completed needed evaluations for individuals identified by the screens. **For Provision J8:** The provision was determined to be not in compliance. Combined assessment and case formulations are being put in place, but most individuals do not yet have them. In some cases, ISPs did not include psychiatric information that is important for the individual. **For Provision J9:** The provision was determined to be not in compliance. "Best practices" cases shared with the Monitoring Team provided the needed clarity regarding which treatments were needed for each individual, and why. However, such clarity is not yet in place for many individuals. **For Provision J10:** The provision was determined to be not in substantial compliance. The Facility was aware of the need for IDTs to discuss alternatives to proposed treatments, and IDTs will be encouraged to do so. **For Provision J11:** The provision was determined to be in substantial compliance. The continued focus on reducing unnecessary polypharmacy has resulted in a gradual and sustained decrease in polypharmacy. **For Provision J12:** The provision was determined to be not in substantial compliance. Facility wide monitoring of side effects was in place, but not all individuals who needed side effect screens had them. **For Provision J13:** The provision was determined to be not in substantial compliance. Improvements were noted in the medication plans. However, the way that medication treatments are monitored for treatment response needs further attention. **For Provision J14:** The provision was determined to be not in substantial compliance. Not all elements of the consent process were in place for the individuals reviewed by the Monitoring Team. **For Provision J15:** The provision was determined to remain in substantial compliance. The process of coordination of care between psychiatry and neurology for individuals prescribed medications for both seizures and mental health disorders was strong.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	There was one change in the physician staffing at the Facility, as Dr. Habbu was newly hired to replace Dr. Lin. Prior to coming to the Facility, Dr. Habbu had experience in both private practice and public sector psychiatry. In an interview with the Monitoring Team Dr Habbu estimated that in his most recent position with the Mental Health/ Mental Retardation authority, about 10% of his work was with individuals who had an intellectual disability. That provided him with sufficient familiarity with intellectual disability psychiatry to be able to provide the needed services to individuals who lived at the Facility. As a result of Dr. Habbu's filling the position vacated by Dr. Lin, DSLLC continued to employ three full time staff psychiatrists, Drs. Habbu, Satpathy and Salam. The fourth psychiatrist, Dr. Harden, was employed as a contractor for sixteen hours per week. The Monitoring Team reviewed the credentials of the psychiatrists. There were no changes in the credentials or licensure for Drs. Harden, Salam and Satpathy. All psychiatrists had current licensure in the State of Texas. Drs. Harden, Salam and Satpathy continued to be Board Certified in Psychiatry, and Dr Habbu was Board Eligible. The psychiatrists' credentials all met the requirements of the SA. During the tour the Monitoring Team observed the work of each of the psychiatrists during their psychiatric clinics, during the infirmary morning meeting, and during the polypharmacy monthly meeting. The Monitoring Team found that the psychiatric staff at DSSLC consisted of qualified professionals, who participated meaningfully in the DSSLC interdisciplinary process.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	At the time of the visit of the Monitoring Team visit, 504 individuals lived at the Facility. The Psychiatry Department provided ongoing support for 241 (48%) of those individuals, all of whom received psychotropic medications. All individuals supported by psychiatry had comprehensive psychiatric evaluations in place. The DSSLC Psychiatry Policy states that in years subsequent to the initial evaluation, updates to the initial evaluation may be done based on the clinical judgment of the psychiatrist. Facility practice was to update each psychiatric evaluation, prior to the individual's annual ISP. In the updates, needed information from previous evaluations was brought forward, new information added, and a new mental status examination was completed. All psychiatric evaluations, initial and updates, were to be done in the Appendix B format (see Provision J6). During the visit, the Monitoring Team assessed continued compliance with the overall diagnostic practices. This was done by observing the daily work of psychiatrists in PMRs and QMRs, in the infirmary daily meetings, and in committee meetings such as the PRC	Substantial Compliance

		and P&TC. The Monitoring Team also reviewed the records of individuals who were seen in clinics during the visits (Sample J1) and the records of the fifteen individuals selected for comprehensive case reviews (Sample J2). The sample of fifteen individuals was comprised of twelve individuals who had been followed by the Psychiatry Department for some time, two individuals who were newly admitted to the Facility, and one who lived at the Facility and was newly referred to the Psychiatry Department as a result of a change in status. For analysis of the Appendix B evaluations of individuals in Sample J2, please refer to Provision J6. <u>The process in place for evaluation and diagnosis:</u> Psychiatrists interacted with individuals and IDT members in many settings. As reported in the self-assessment, psychiatrists were now regular attendees at annual ISP meetings, and they participated in both routine and crisis management IDT meetings as the circumstances required. Psychiatrists at the Facility all conducted scheduled meetings with individuals in the psychiatry clinic. These meetings were known at the Facility as Psychiatric Medication Reviews (PMRs) and Quarterly Psychiatric Reviews (QPR)). These appointments were also attended by several IDT team members, including the QDDP, psychologist /behavior analyst, nurse case manager, clinical pharmacist, and selected DCPs who knew the individual well. Appointments typically lasted about 45 minutes. All individuals assigned to a psychiatrist for ongoing care met with the psychiatrist at least quarterly, and more commonly, they met monthly. As the clinical circumstances required, psychiatrists observed and/or interviewed individuals, sometimes in an office setting and sometimes at the individual's workplace or other setting. <u>Review of Diagnoses During PMRs:</u> One of the items reviewed at each PMR was the individual's diagnosis. To assure that this was done, the form completed during the PMR had an item that inquired whether the diagnosis had changed. During one of the clinics observed by the Monitoring Team, a change in diagnosis was made. The individual in question was Individual #311, who had the diagnosis of Schizophrenia, Chronic Paranoid Type (DSM 295.30). During the PMR the psychiatrist interviewed the individual and conducted a mental status examination. The psychiatrist then drew on his knowledge of the individual's past course of illness to inquire with the IDT psychologist, nurse case manager, and DCPs about the presence of some of the key symptoms of the individual's illness. The psychiatrist documented the mental status as follows: *(The individual) is somewhat overdressed for the occasion, wearing a jacket throughout the meeting. He is notably attentive to the process, responding to questions promptly with speech volume that is low, fluency is poor, rate is rapid at times and difficult to comprehend, eye contact floating. He does not appear*	

		internally preoccupied; affect is flat, mood slightly depressed. Behavior is largely appropriate, motor activity is unremarkable. In his assessment, the psychiatrist wrote: *Patient's symptoms and behavior over the recent quarter are not significantly changed. Clinical appearance is largely unchanged from the past meeting; he does not appear to be in active phase of his schizophrenia… Symptoms seen in speech and affect, no medication side effect noted, Moses and Discus remain at zero. Lab data is unimpressive.* As a result, the psychiatrist then wrote: *I will change Axis I diagnosis to Schizophrenia, chronic, residual type, (DSM 295.60)* The documentation of the reasons for the change in diagnosis described above was an example of good practice, since it addressed the key issues that the DSM requires for the diagnosis of residual schizophrenia, namely (1) the absence of prominent delusions, hallucinations, disorganized speech or catatonic behavior, and (2) the continued evidence of the disturbance as indicated (as in this case) by the presence of negative symptoms (the definition continues with circumstances that do not apply to this individual.) The comments provided by the psychiatrist in the PMR note provide the basis for the change in diagnosis. It will be important for the psychiatrist to refer to the diagnostic change, and the particulars that support it, in the next annual psychiatric summary. Timeliness of the Evaluations: The two new admissions were evaluated in a timely manner: both had assessments done during the first 30 days of admission. Annual evaluations for the 15 individuals in sample J1 were all done in a timely manner, prior to the PSP meeting. <u>Review of psychiatric evaluations for individuals newly admitted or newly referred:</u> The Monitoring Team reviewed three psychiatric assessments. Two were new admissions and the third was a referral for psychiatric assessment from the IDT of an individual who lived at the Facility but did not receive psychiatric services. Individual #679 was admitted on 10/10/11 and had an initial psychiatric evaluation on 10/26/11. It was brief and did not address, for example, which psychiatric symptoms are addressed by the medications since the documentation was not available at the time the assessment was done. In this situation it was good practice to record available information close to the date of admission, but the evaluation should have been revisited as fuller information became available.	

		Individual #476 was admitted on 01/05/12 and had a psychiatric evaluation on 01/17/2012. Similar to Individual #679, the evaluation was somewhat brief for an Appendix B evaluation and not all required areas were covered – for example developmental and social histories. Here, too, information should have been added later. The third was Individual #158, seen as an internal consultation due to a change in status. He was a long term resident of DSSLC and had developed symptoms of sleep disturbance with evidence of anxiety, irritability and restlessness. The evaluation provided a good working understanding of the individual and was adequate to initiate initial steps of treatment but should have been be expanded as more information was obtained and a better understanding was developed, for example about the role of anxiety and irritability. <u>Facility process to track diagnoses and diagnostic updates:</u> The Department of Psychiatry maintained a spreadsheet (referred to internally as a database). It was maintained by the two psychiatry assistants. The spreadsheet listed the individual's diagnosis, the Facility psychiatrist responsible for care, and psychotropic medications. Information from the database was available to appropriate Facility staff to assure that psychiatric information is cited correctly by members of other departments. The psychiatric diagnosis is tracked by the primary care physician and is cited in the Active Problem List (APL) which is completed annually. The Monitoring Team examined the 15 clinical records for the individuals in Sample J2, and compared the current psychiatric diagnosis and the APL. In most case the information in the two sources was the same. However, Individual # 679 was listed in her APL of 09/18/11 with non-DSM diagnoses of Behavior Problem and Mental Disorder mood disorder and depressive disorder NOS. The latter were discontinued in 2009 and 2010. The current diagnoses of Cyclothymia and Phonological Disorder were not listed. The APL for Individual #612 contained "history of" diagnoses that were not active problems. Overall, the Facility has a good process in place for conducting psychiatric evaluations. Because the Facility continued the practices for which it was rated in Substantial Compliance at the last compliance visit, this rating will be maintained. However, for continuing compliance at the next visit, the Facility must ensure timely completion of evaluations.	
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	At the time of the last monitoring visit the Facility was found to be in noncompliance with this provision. In many cases the description of the treatment program was lacking, and the Monitoring Team was not able to be sure that medications were not being used as a substitute for a treatment program. During the first several visits, the Monitoring Team noted that information about	Noncompliance

	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.	medication treatments was often lacking. For example, there was often a lack of clarity about the rationale for the use of medication and the way it was related to the psychiatric disorder with which the individual was diagnosed. Also, it was difficult to tell whether the medications were used for a psychiatric disorder or for behavioral control. In some cases, information about medication side effects was inconsistent or lacking, as was information about the relative benefits and risks of the medication. Over the course of 2011 and early 2012, the Facility made improvements in the above areas. During the last visit the Monitoring Team was given improved templates for the PBSP that provided a much clearer presentation of the information required by the SA (in that case, as part of Provision J13) and by DADS internal guidelines for medication information that was required in the PBSP. In January 2012 the Facility then developed a draft of a revised PBSP format that includes a section for discussion regarding differentiation between functional behaviors and psychiatric symptoms. To assess continued progress toward answering the requirements of the SA, the Monitoring Team examined examples of the PBSPs written recently in the new format, reviewed the records of fifteen individuals for Sample J2, and observed practices related to the use of medication by attending PMRs and quarterly medication reviews (QMR) during several psychiatric clinics. <u>Presence of a treatment program:</u> As above, the focus of this provision is that medications should not be used as a substitute for a treatment program. At DSSLC the overall treatment described was the ISP, and the focus for the behavioral treatment program was the SFA and Positive Behavior Support Plan (PBSP). The former provided the details of the behavioral treatment program, and the latter provided much of the basis upon which that program was constructed. PBSPs were provided for 12/15 individuals. All contained needed information on the individual's psychotropic medications. <u>Elements of the Treatment program</u> As part of the evidence book provided to the Monitoring Team, the Facility provided PBSP's for three individuals. These were reviewed for evidence of key elements for psychiatric care: |	Individual #482	Individual #372	Individual | | --- | --- | --- | --- | | Psychiatric Diagnosis | Autism | Autism | Mood diso chronic pa | | Medication | Seroquel for | Seroquel for | Zoloft for s |	

		and related psychiatric diagnosis	impulsivity irritability, hyperactivity and mood lability, related to autism	irritability and agitation, related to autism	depression	
		Details from Medication Plans (MP) as to how the medication will be monitored.	Monitored by psychologist for symptoms of repetitive movements/activities, inappropriate touching, sleep disturbance	Irritability and poor frustration tolerance that results in agitation	Labile mood increased crying spells, irritability, and poor frustration tolerance	
		Data reported on in the PBSP graph for psychiatry	Repetitive movements, amuses self, wakes frequently, touching: reported on a rating of 1 to 3.5	Insomnia, agitation and aggression	Aggression, irritability, impatient, resists guidance	
		Information about medication use - timeline for effects, dose range	present	present	present	
		Side effect information	Yes, per MP	Yes, per MP	Yes, per MP	
		For Individual # 61, while the medication plan is clear what data should be collected to assess response to Zoloft - that data is not reported in the PBSP graph for psychiatry. For Individual #482, most of the symptoms identified in the medication plan are reported in the PBSP, but not sleep. It is not clear why not. Also, the graph for psychiatry reports data on a 3.5 scale for frequency. It is not clear what each value on the scale means. Additionally, it is not clear how the scale provided in the PBSP was constructed. For				

		Individual # 372, irritability and poor frustration tolerance (that result in agitation) are identified as the targets to be monitored for Seroquel, but the PBSP reports only agitation and aggression. This could be problematic if those are also symptoms of the psychology monitoring for learned behavior. <u>Observations made during PMRs:</u> During the visit the Monitoring Team attended PMRs and QMRs for six individuals. For several of those individuals, information was presented that related to the differentiation of psychiatric and psychological treatment data: • Individual # 183 was diagnosed with intermittent explosive disorder and was medicated with Zyprexa and Depakote. For each medication, the psychiatrist had identified that the medication was used as a mood stabilizer, and agitation and self injury were the measures for treatment response. The PBSP for this individual was written in 2011 and did not present the psychiatric data in the new format. The most recent PMR did present a graphic summary of psychiatric data that was separate from the graph of psychological treatment data. However, the PMR listed aggression and self injury as psychiatric targets and these same behaviors were listed as targets of the overall behavior plan. That was problematic, since there was no clear differentiation between the two sets of data. There can be collaborative case formulation in which both psychology and psychiatry address both diagnostic symptoms and behavioral targets, but psychotropic medications must address psychiatric disorders. In cases like this, there should also be data to track the psychiatric component, perhaps an individualized measure that focuses on the element(s) of behavior that exemplify core diagnostic symptoms and may not be accounted for by the functional assessment. The team had a useful discussion about the fact that the individual was doing well and might be able to transition to community based care; arrangements for this were already underway. The team was not able to point out how the effects of the medication would be monitored or even to state whether or not there was evidence that the individual received benefit from the medication. • Individual # 321 was diagnosed with intermittent explosive disorder and was treated with Zyprexa, Depakote and Tegretol. The medication plan for Zyprexa identified that the drug was used as a mood stabilizer to control episodic mood swings and impulsive aggression, and the target psychiatric symptoms were mood lability, impulsivity and irritability. Per the pharmacy list of anticonvulsant medication uses, Depakote and Tegretol were prescribed as dual purpose medications, used for both psychiatric disorders and epilepsy, and the psychiatric targets were mood lability, impulsivity and irritability. Although the PBSP was	

		recently revised (02/28/12), it did not present separate psychiatric and behavioral data. Similarly, the PMR did not present separate psychiatric and behavioral data. Also Depakote was described in the PMR notes only as an anticonvulsant, and Tegretol was described only as a mood stabilizer. These facts were problematic, particularly since the psychological and psychiatric symptoms that were monitored for treatment response were the same. Although the Facility had presented that new plans would try to monitor behavior in a manner that differentiated functional behaviors and psychiatric symptoms, it did not appear to do so in this case. After the individual had left the room there was a discussion between the IDT psychologist and psychiatrist, in which the psychologist shared that she typically could tell whether the self injury was related to a functional behavior or a psychiatric problem, even though the end result of self injury was the same. In such cases it is important for the psychologist to clarify how this was done, and for the manner in which that was to be documented. Quality of the monitoring for psychiatric target symptoms: The system of psychiatric treatment monitoring was centered on observations made by IDT psychologists, and these observations are guided by operationally defined characterizations of the target symptoms for the psychiatric treatments. In previous visits the Monitoring Team had expressed concern that although psychiatrists had listed target symptoms for medication treatments, little data was collected to provide a measure of effect of treatment on those targets in question. During the last visit the Facility shared that data collection would be individualized, and based on observations made by IDT psychologists. The Facility also clarified that observations would be guided by operationally defined characterizations of the target symptoms. Review of the 15 case reviews showed that one of the individuals did not take medication and was no longer followed by psychiatry. For the other plans, 10 of 14 PBSPs (71%) did not report appropriate data for the targets identified on medication plans. In most cases, this was because the medication plans did not make clear what information the psychologist would collect and report to provide monitoring for the identified target. This matter is explored in more detail in the analysis of new medication plans under provision J14. The Facility reported similar findings in its self-assessment: It had reviewed records of individuals who received psychiatric care and services and found that in 100% of the sample, the psychiatrist had identified the psychiatric diagnosis and associated manifest symptoms, but that tracking of the symptoms needed improvement to match those	

symptoms.

In many of the fifteen cases in Sample J2, the Monitoring Team found that there were excellent descriptions of the behavioral characteristics/psychiatric symptoms in the PBSP and the SFA that could have been used as indicators of medication response. However, it was not clear from the record exactly how the numerical ratings that were reported were constructed and what data was used to make the ratings that were in the PMRs and PBSPs. For example, Individual # 605 was diagnosed with Bipolar Disorder and was treated with Zyprexa, Klonopin, Lunesta and Trileptal. The (FA) for this individual was examined and it contains valuable descriptions of the symptoms this individual has when she was manic:

"*When (the individual) is manic she is easily agitated, will yell obscenities and insult others, her thoughts race, her mood changes rapidly, she often appears to hallucinate and she becomes extremely aggressive toward everyone around her. When her bipolar mania is at its worst, (the individual) may not sleep for several days in a row. "*

Or

"(*The individual) had had numerous manic episodes in which she experiences the following symptoms: irritability, agitation, increased aggressive and violent behavior, euphoria, elated behavior, rapid and disjointed speech, illogical and delusional thoughts, high energy level, insomnia and hallucinations. She has reported seeing people, devil, and witches in the past."*

Elsewhere in the Functional Assessment (FA) there is a listing of the clear signs that the individual showed when she escalated into mania. These symptoms included:

- Use of excessive eye makeup
- Use of excessive lipstick around the lips
- Carrying a large number of bags and excessive jewelry
- Blaring loud music in her room and tuning up her television to unreasonably loud levels simultaneously
- Changing the radio station she plays in her room from R&B music to classic rock stations
- Loss of multiple nights of sleep, racing thoughts and disconnected speech

This wealth of clinical information notwithstanding, the PBSP and PMR provided a numerical rating without any description of how the rating was made. In such cases there needs to be a description of how the ratings were made. Please see provision J13 (medication plans) for further discussion about behavioral ratings.

<u>Timeliness of PBSP reviews:</u> The Monitoring Team reviewed the 19 examples of new medications that were approved for use since the last monitoring visit. Review showed

		that in 14 of 19 cases, (73%), a new PBSP had not yet been revised to accompany changes in medication. This was consistent with the finding of the Facility's self assessment. In that assessment the Facility reviewed 20 records, and found that in the majority of cases PBSP's were not current. <u>Medications used for staff convenience:</u> To determine whether this was ever done, the Monitoring Team addressed this question by examination of the records, and by observations made during PBMCs, during BSC, during the psychology department meetings, and in interviews with staff. There was no direct evidence that medications were used for staff convenience. However, there were many plans in place where the only identified targets continue to be disruptive behaviors that were not directly linked to any psychiatric diagnosis. Therefore, documentation did not clearly identify that the purpose for use of the medication was to treat a diagnosed condition rather than to reduce disruptive behavior. <u>Medications used for punishment:</u> To determine whether this was ever done, the Monitoring Team considered observations made during the tour, and examined the records of the 15 individuals in Sample J2. There was no evidence that medications were used for punishment. <u>Chemical restraints use:</u> There were no chemical restraints during the review period. Overall, the Monitoring Team found that there has been good progress in the area of psychotropic medication use. In particular, the Monitoring Team noted an improvement in the descriptions of medication treatments and possible side effects in PBSPs Also, there were improvements in the way that medication treatments were guided by a diagnosis or specific behavioral pharmacological hypothesis. These improvements notwithstanding, much work remains to be done. In particular, efforts should be made to ensure that psychiatric treatment will be supported by data on observable and measurable behavioral characteristics (see also provision J13).	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be	The Facility's approach to pretreatment sedation was guided by (1) DADS Policy and Procedure 001 - Use of Restraints (08/15/09), (2) DSSLC Procedure CMGMT 24 : Desensitization (12/15/11), and (3) DSSLC Nursing Guidelines for Nursing Responsibilities Related to Restraints (updated 02/16/12). <u>Medical monitoring of medical restraint (pre-treatment sedation)</u> The Monitoring Team met with Jill Wooten, with Sibylle Graviett RN, Case Manager Supervisor, with Delia Schilder RN, CNE, and with others from the Nursing Department to review how safety monitoring was provided during and after oral and/or IV pre-treatment sedation for medical and dental procedures. Ms. Schilder and Ms. Graviett informed the Monitoring Team that when IV sedation was used, nurses accompanied	Noncompliance

	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.	individuals from the residence to the dental clinic and monitored the individual for safety with the sedation checklists. Vital signs were obtained at least every 30 minutes or more frequently if so ordered by the physician or dentist. Monitoring continued in the infirmary until scores of 8 or higher on the REACT measures for level of sedation were obtained. Care after release from the infirmary was guided by orders by the physician or dentist and more generally, the DSSLC Acute Care Nursing Plan for Post Anesthesia Care. That protocol called for vital signs and REACT scores every 15 minutes after release from the dental recovery area, for hourly vital signs for the first two hours after release from the infirmary, and then at least once per shift for 72 hours, To review whether monitoring done followed the protocol described above, the Monitoring Team sampled 9 individuals who had received medical or dental pre-treatment sedation in six months that preceded the visit of the Monitoring Team. Individuals who had TIVA sedation, oral pre-treatment sedation for dental procedures, and oral pre-treatment sedation for medical procedures were sampled as follows: • Dental procedures with TIVA sedation: Individuals #209 (1-12-12), #731 (12-14-11), and #772 (2-13-12) • Dental procedures with oral pretreatment sedation: Individuals #222 (12/18/11), #332 (11-29-11), and #311 (11-06-11) • Medical procedures: Individuals #398 (2-10-12, CT spine), #210 (10-13-11, Doppler study), and #360 (2-3-12, Mammogram) Difficulties noted in the review included: • The Monitoring Team examined the records for evidence that vital sign monitoring was obtained during and after the procedure with the frequency outlined by the Facility protocols. Lapses were noted in each record. • The Monitoring Team examined the records for evidence that REACT scores were obtained as required. No evidence was provided for Individuals #332 and #210. In addition, for Individuals #209, #311, #506, and #731 the check list used to complete the REACT rating was either not dated/timed, or the information was not listed on the pre-post-sedation form. • The Monitoring Team examined the records for evidence of continued monitoring for 72 hours after the individual was released to his/her home, per the Facility protocol. These were not provided. • In the case of Individual #360, no evidence for medical/nursing monitoring was provided. The Monitoring Team notes that the reviews were done via copies made of the documents; it is possible that documents existing in individuals' records but were not provided to the Monitoring Team	

		Efforts to reduce the need for medical restraints during routine medical and dental procedures: The Facility provided the Monitoring Team with a list of Medical/Dental Support Plans. As part of its quality assurance efforts, the Facility reported in the Self-Assessment dated 03/16/12 that it had reviewed the list of individuals who required pre-treatment sedation for routine dental treatment, and concluded that few desensitization plans had been developed since the last visit of the Monitoring Team. In a meeting that took place on 4/2/12 with Jill Wooten BCBA, t he Monitoring Team was informed that the position for a psychology assistant who would work with the Dental Department to reduce the need for restraints had been vacated in December 2011. The position was filled in March 2012 by Ms. Karen Bishop. Ms Bishop participated in the meetings led by Ms. Wooten, in which the need to continue to develop procedures to minimize the need for medical restraint was discussed. Since the last monitoring visit the Facility has developed a procedure on desensitization. That document clarifies that in general three attempts should be made to treat the individual without sedation, before pretreatment sedation is considered. If Medical/dental sedation is required for the routine medical or dental treatment, the individual is to be referred to the IDT to consider efforts to reduce the need for use of the sedation. The Monitoring Team was given a list titled "Desensitization List" which listed 153 individuals, whether they had a plan, and for those who had a plan, its type. Only one of the individuals sampled by the Monitoring Team had a plan in place. That was Individual #731. The plan called for the individual to walk to the administration building where the dental clinic is located and for the individual to stay for less than one minute in 20 of 24 data points by 1/2/13. The Monitoring Team was provided with a data sheet that showed three such data points in March 2012. Overall status of efforts to minimize the need for pre-treatment sedation and the need to monitor for safety: The Monitoring Team found that the development of plans to minimize the need for medical restraints were still at an early stage.	
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	At the time of the visit, 241 of the 504 individuals who lived at the Facility received psychiatric support. The Facility continued to employ three full time staff psychiatrists and one part-time contract psychiatrist for a total of 3.4 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	Substantial Compliance

	necessary for implementation of this section of the Agreement.	polypharmacy and management of the Facility-level reviews of individuals known to have tardive dyskinesia. Based on the information provided in the Department of Psychiatry spreadsheet, Dr. Salam was the attending psychiatrist for 72 individuals. Dr. Satpathy continued as a full time Staff Psychiatrist and was active with several Facility Committees. He had a caseload of 77 individuals. Dr. Habbu was new to the Facility, and was still in orientation at the time of the visit. His caseload was largely comprised of individuals who had previously been under the care of Dr. Lin, who is no longer on the staff of the Facility. Dr. Habbu's case load was 72 individuals. Dr. Harden continued as the contract psychiatrist. He has worked at the Facility for many years, and has continued his activities in the area of quality assurance for psychiatry. Dr Harden also carried a caseload of 26 individuals. Psychiatrists participated in routine clinical activities, which included PMRs, QPRs, ISPs 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. During the last visit the Monitoring Team had requested that the Facility provide a self-assessment regarding how many psychiatry FTEs were needed, based on the number of individuals currently treated in the psychiatry clinic. Dr. Salam provided the Monitoring Team with a detailed time study. In the study Dr Salam indicated the need for a total of 122 quarterly and routine follow-up clinic appointments, participation in ISP meeting, participation in IDT meetings, participation in morning report, P&T and PRC meetings, in quality assurance and POI meetings, and other required Facility activities. Dr. Salam provided detailed line items that substantiated the need for 672 hours of psychiatry per month, compared to the current level of effort which was 3.4 FTE or 589 hours per month. Dr. Salam also reported that the caseloads were busy, but manageable. Another way of estimating staffing needs was to calculate the average number of individuals supported by each FTE psychiatrist. In the case of the Facility, that was 71 individuals who received active psychiatric treatment, for each FTE psychiatrist. That	

		clinical load was comparable to that of psychiatrists at some other DADS facilities. The Monitoring Team concurred with the Facilities that that there was a sufficient number of board certified or board eligible psychiatrists, to provide the services required by Section J of the SA.	
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.	To evaluate compliance with this provision the Monitoring Team reviewed the psychiatric evaluations of the fifteen individuals in Sample J2. As described under Provision J2, Facility practice has been for individuals to receive an annual psychiatric evaluation, prior to their annual ISP meeting. Since typically, evaluations were already in place, the Facility opted in 2010 to transition the existing evaluations into the Appendix B format at the time the annual re-examination was done. For most individuals, that meant an expansion in the scope and the depth of materials included in the existing evaluations, and a transition of those and new materials into the Appendix B format. In the 3/16/12 Self-Assessment, the Facility found that progress had been made in the area of Appendix B evaluations, while also acknowledging that some documents needed further explanation for clarity. The Monitoring Team's review of the psychiatric evaluations for individuals in Sample J2 also showed that there was progress. For example, at the time of the visit, a large majority of not-otherwise-specified (NOS) DSM diagnoses were reported to have been resolved. Also, there was continued improvement in the detailing of past treatment trials. That information was important since it helped guide current treatments. Nonetheless, the Monitoring Team found that much work remained. The area of most need is that of diagnostic justification, the requirements of which were spelled out in the Appendix B format, in DADS Psychiatry Policy, and the DSSLC Psychiatry Services Policy. The Monitoring Team reviewed the psychiatric assessments of the fifteen individuals in Sample J2. Many problems related to diagnosis were noted. The most common problems were instances where the psychiatrist stated that the various symptoms met criteria for Axis 1 and Axis II diagnoses, but did not specify how (for example, see Individual #151). Sometimes it was possible for the Monitoring Team to deduce how the individual met the needed diagnostic criteria, but not always. The second common problem was the case where the psychiatrist noted symptoms that were consistent with a diagnosis, but were not sufficient to make that diagnosis. Examples selected from Sample J2 were: • For Individual #746 the assessments stated "s*ymptoms of mood lability, ranging from laughing and crying rapidly and self- injurious and aggressive behaviors met criteria for Cyclothymia.*" However, several of the criteria that are required for the diagnosis of Cyclothymia were not addressed, and the evaluation should have briefly commented on the reasons that Cyclothymia was selected over the	Noncompliance

		diagnosis of affective disorder. • The evaluation for Individual # 158 stated "*Evaluated today and diagnosed with autism. His history of cognitive deficits, lack of language and social skills, and stereotypic behaviors maladaptive behaviors meet criteria (for the disorder).*" The cited symptoms are consistent with the diagnosis of Autism, but the presentation was not sufficient to make that diagnosis. Challenges noted in the evaluations went beyond the issue of diagnostic justification: In some cases, the transition from the prior to the current format did not go well: Since the format of Appendix B was considerably broader and more in-depth than what existed previously, there was a need to expand the scope of the evaluation and bring new information into the evaluation, sometimes from assessments that were located elsewhere in the record. The transition from an annual update in the prior format to a stand-alone comprehensive evaluation that could be the basis for work going forward also meant that there was a need to retrieve information from previous psychiatric records. The overall work is necessarily time consuming; in some cases it appeared to the Monitoring Team that the product was perhaps rushed, and that evaluation was clearly incomplete. Sometimes, the evaluations appeared to be merely annual updates of the existing evaluations. In other cases the new format was followed, but critical sections - for example case formulations - were somewhat cursory, and failed to provide a sufficient understanding of the psychiatric illness, or sufficient information on how the psychiatric symptoms were linked to the diagnosis, or sufficient detail on the status of treatment. An example of the above was the evaluation for Individual #258, in whom the Description of Current Psychiatric Illness and Past Psychiatric History sections (apparently replacing the History of Present Illness section of the required format) was a short update, in which the reader was not provided the background needed to understand the symptoms that were mentioned. Another example was that of Individual #605 where no Axis III Diagnosis was listed and the reader was referred to the medical history section, and then to the annual physician summary. As a result, the medical section of the comprehensive evaluation was incomplete, and in the absence of an Axis III diagnosis, the reader was not informed as to which medical difficulties were deemed relevant to the understanding and management of the individual's mental disorder. The Facility took on a tremendous task in attempting to convert close to 250 evaluations to the new format in the course of one annual cycle. The efforts to date have resulted in considerable improvements, but additional work is needed. As psychiatric evaluations are updated prior to the ISP meeting and at other times, they should be reviewed and expanded as necessary, to make sure that in each case relevant information is collected and assembled in a manner that will provide the needed comprehensive evaluation.	

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.	At the time of the visit of the Monitoring Team, there were 241 individuals under the care of the Psychiatry Department. Each of these individuals had received a comprehensive psychiatric evaluation, and they were not required to have a Reiss Screen in place. Two of these individuals had been admitted to the Facility after October 01, 2011: Individual #679 was admitted on 10/10/11 and had a comprehensive psychiatric evaluation on 10/26/11. Individual #476 was admitted on 01/05/12 and had a psychiatric evaluation on 01/17/2012. In the report for the previous compliance visit, the Monitoring Team wrote that they had questions about the Reiss Screens for Individuals #45, #208, #304 #332, #367, #376, #508, and #581. These were reviewed during the current compliance visit. All were determined to have been positive screens that required follow-up. During the visit the Facility demonstrated that Individuals #45, #304, #367, and #508 had received psychiatric evaluations. Individuals # 208, #332, #376, and #581 had not. In addition, the Monitoring Team was newly notified that Individuals #1, #113, #141, #239, #408, #506, #572, #655, #674, #738, and #741 had been identified as having positive Reiss Screens, and they too had not received the required follow-up. During the visit, the Facility provided the Monitoring Team with a plan to complete the needed assessments for the fifteen individuals who required them. The Facility reported that Reiss Screens for all other individuals who lived at the Facility and who did not received care from the Psychiatry Department had received the Reiss Screen, and the results were negative. This included Individual #355, admitted on 11/29/1, and who was not followed by the Psychiatry Department. The Monitoring Team sampled 20% of the Reiss Screens that were reported to be negative, in the following manner: the Monitoring Team requested and received the Reiss Screen and scores for every 4th individual on the list of negative Reiss Screens until the required number of screens had been selected. The individuals selected in this manner were Individuals#2, #23, #37, #126, #130, #148, #167, #177, #189, #192, #214, #221, #307, #310, #314, #320, #333, #385, #392, #394, #398, #429, #430, #445, #452, #462, #499, #532, #536, #560, #571, #602, #659, #672, #695, #697, #699, #710, #713, #715, #740, #742, #759, #761, #768, #769, and #775. The Monitoring Team confirmed that the screens for these individuals were negative. In addition to the required use of the Reiss Screen, the Facility also used the screen as part of an evaluation of individuals who lived at the Facility and were referred for psychiatric evaluation/services. This was the case for Individual #158, who is discussed under Provision J6.	Noncompliance
J8	Commencing within six months of	The core mandate of the provision is that there needed to be an interdisciplinary effort to	Noncompliance

	the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	achieve a combined assessment and case formulation. Without such joint case formulations, it is difficult to see how pharmacological treatments could be integrated meaningfully with other behavioral interventions or how recommendations could be made for particular modalities of behavioral treatment. On 7/22/11, the Facility began to use a new PBSP format that combined psychology and psychiatry plans into one integrated document. On 1/23/12 the Facility revised the PBSP format to include a section for discussion regarding differentiation between functional behaviors and psychiatric symptoms. Psychiatry and psychology continued to have discipline-specific evaluations. For psychiatry it was the psychiatric evaluations and annual psychiatric updates. At the beginning of the visit, the Facility provided an evidence book to the Monitoring Team. This included materials that demonstrated the progress achieved over the previous six months. For Provision J8, the Facility provided PBSPs that had been written recently. These were reviewed to get a sense of current Facility practice regarding combined formulations. The Monitoring Team found evidence of effective integration of materials from psychiatry and psychology in the overall formulation. For example: • Individual #372 was diagnosed with Autism and he had challenging behaviors that were the focus of behavioral interventions. These were physical aggression to others, aggression to property, and verbally disruptive behavior. In the psychiatric formulation the psychiatrist noted the individual has mood difficulties which lead to frustration and ultimately irritability. Although mood difficulties are not part of the core definition of autism, such symptoms can be a secondary features and it is reasonable to link the symptom to the diagnosis. In the "Identification of the Problem and Discussion" section of the PBSP both the psychological and psychiatric formulation are presented side by side. In the "need for behavioral support" section, rationales are offered to support both behavioral and psychiatric treatments. The date of the PBSP was 2/27/12. • Individual # 482 was also diagnosed with Autism. A combined clinical formulation was evident in several PBSP sections. In the "Fundamental Outcomes" and Identification of the Problem and Discussion" sections the IDT provided descriptions of behaviors including "night rituals" (described as repetitive stereotypies) and hyperactivity, both of which were linked to the autism and were treated with medication. Separately, the functions of the night rituals were assessed by psychology and seemed to have some sensory elements, and the hyperactivity did seem to be reinforced by the attention he obtains. Nonetheless, in this example psychology (in the "Functions of Behavior") section presents that much of his behavior does not have a clear functional purpose and the Autism is then evoked as the etiology for many behavioral characteristics, such as repetitive/stereotypic preoccupations.	

		Although improvements were evident in the sample cases provided, the Facility also acknowledged in the 3/16/12 Self-Assessment that PBSPs were not current for many individuals. This effected several provisions of the SA that related to integrated care. One such example was information about medication plan, as reviewed under Provision J13. The Monitoring Team also assessed integrated care by reviewing the ISPs of the individual in Sample J2, to see if they included information on the key issues for psychiatry. The results were variable. For some individuals, for example Individuals #158, #228, #269, and #746 key information regarding the individual's psychiatric status was included, but for others, key information was lacking. For example: • Individual #781 was diagnosed on Axis I with a mood disorder and on Axis II with a personality disorder. She was medicated with Klonopin, Abilify and Trazodone for target symptoms of mood instability, anxiety, and irritability. The ISP description of her behavioral status was that "*she can be highly demanding and engage in maladaptive behaviors that could potentially result in major injury to herself or others*. *She is seen in the psych clinic where her medications are monitored and she is monitored by both the behavior analyst and psychiatrist. The team agreed that she should continue to be seen by a psychiatrist in an effort to minimize her behaviors."* Neither the psychiatric target symptoms nor the efficacy of treatment were addressed and there was no information about her treatment in the psychiatry clinic. There should have been more detail about what was being done, and something about the results of the interventions that had been offered. Overall, the Monitoring Team found that integrated care has been improving, but continued attention to this area is needed.	
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	The most recent compliance report focused on the need for the Facility to improve the process by which IDTs evaluated the individual's needs and then recommended that the individual should be referred for various modalities of treatment. In the 3/8/12 action plan for the provision, the Facility identified three steps that were taken to address the findings of the Monitoring Team. These included: 1. Continued improvement in combining assessment and case formulation by psychiatry and psychology departments, 2. PBSP inclusion of discussion about psychopathology, MPs, tracking of data for psychiatric symptoms, and combined psychiatric and psychological assessment of the individual, 3. PBSP inclusion of attempts at least restrictive practices, rationale for selecting a particular treatment option and use of other/non-pharmacological interventions to support the individual.	Noncompliance

	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.	A target date of 09/30/2012 was provided for these efforts. In the evidence book provided by the Facility to the Monitoring Team there were two recent PBSPs selected to illustrate current Facility practice. Each was reviewed: • Individual #165 was diagnosed with Autism. He experienced many symptoms that are characteristic of that disorder, such as stereotypic spinning in circles for longer than 30 seconds while nervously pressing his knuckles to his face. The aspects of the individual's autism that were the focus of behavioral treatment were those symptoms/behaviors that had interfered with his preferred activities, or that placed him or others in danger of injury. Behavioral supports were provided to the individual to appropriately and effectively communicate his needs, and to increase tolerance to necessary delays, when his preferred items could not be delivered immediately. Medication treatment was provided for reasonable medication targets, like insomnia and hyperactivity. The paragraph on differentiation between learned problem behaviors and psychiatric symptoms made clear that symptoms like repetitive behavior could have both functional and psychiatric underpinnings and provide a good justification for concurrent treatment, if the team elected to do so. • Individual # 258 was diagnosed with Asperger's syndrome. The treatment plan addressed adaptive elements for the individual, who loves to talk about sports, soap operas and Spiderman, and who likes to use the computer to search for these preferred topics. The behavioral component of his treatment stated that escape from unwanted situations of task demands may be a basis for a learned response of threatening behaviors. His predisposition to stereotyped patterns of response was discussed as related to both the Asperger's syndrome and to possible learned elements of behavior, such as his preoccupation with eating at night. The PBSP provided an integrated understanding of the individual and his needs. The main weakness was a relative lack of input from other treatment approaches beyond those offered by psychology and psychiatry. Based solely on reading the PBSP, the individual appeared to be a good candidate for many habilitative therapies, formal and informal. In broad terms, both examples offered by the Facility acknowledged that the individual in question had both psychiatric and psychological components to the behavioral profile. In each case an effort was made to explain what was being done by each discipline, and why. In each case an effort was made to provide integrated understanding of the individual, and in each case that understanding was cited to justify the choices of treatment. During the visit, the Monitoring Team reviewed the continued involvement of the psychiatrists in the IDT process. To do so, the Monitoring Team attended psychiatric clinics of each of the four psychiatrists. The Monitoring Team found that DSSLC psychiatrists continued to be actively involved in the IDT process. Psychiatrists were	

		active participants in all PMRs and QPRs, and that positive process was observed in all four psychiatry clinics observed by the Monitoring Team during the visit. During the clinic, the psychiatrists' inquiries went well beyond medication monitoring. They had questions about how behavioral interventions took place on the unit, how an individual did during a visit to a possible group home placement, how new workplace assignments impacted on the symptoms that were of interest to psychiatry, and many other aspects of the broader behavioral treatment plan. Participation in the psychiatry clinic was broad, and included nurse case managers, QDDPs, other professionals such as an IDT member from occupational therapy, a volunteer advocate from the community and others. Discussions on the design and the implementation of treatment programs were clinically solid. In the 3/16/12 self-assessment, the Facility acknowledged the new PBSP format was implemented on 2/23/12 and that PBSPs were not current for many individuals. A target date of 9/30/12 was set. That date might not be realistic, as the improvements recently put in place will need an annual cycle to be applied to all individuals, assuming that the revisions in the PBSPs would take place at the time of the annual review of that document. Overall, the Monitoring Team found that the Facility was making progress in addressing in the requirements of the provision.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	<u>Clinical Process:</u> The main place in the Facility clinical process where discussions about medication (including risk/benefit analysis) took place was the psychiatric clinic (PMR and QMR). Typically, IDT participation in the clinics included the psychiatrist, QDDP, nurse case manager, psychologist and Direct Care Professionals (DCP). Primary care physicians (PCPs) attended when possible. When the PCP was not present and a medication plan was developed, the psychiatrist called the PCP, and discussed the relevant issues. Medication issues broadly, including discussions about risk/benefit, could also be part of any IDT discussion. Facility functions, for example the PRC, P&TC, and the medical morning report, were other venues where these issues were also discussed. For example, during the compliance visit, the Monitoring Team attended the morning report on 4/3/12, during which Individual #351 was discussed since he had gone into the hospital for possible aspiration pneumonia. During a previously scheduled PMR that took place on 4/2/12, the team conducted a risk assessment, and during the medical meeting there was some discussion about the risk and benefits of the current psychotropics, Risperdal and Klonopin. <u>Documentation:</u> For new medications risk/benefit discussions were documented in the MP. As part of informed consent procedures, the information was reviewed by HRC and PBRC and included in the revised PBSP. For ongoing medications, the primary place was the QMR	Noncompliance

		and PBSP. The Monitoring Team reviewed medication plans for 19 medications that were newly started over the past six months, These were for Individuals #35 (Abilify), #108 (Cymbalta), #158 (Remeron), #171 (Zyprexa), #194 (Prozac), #240 (Saphris), #247 (Trazodone), #306 (Cogentin), #397 (Lexapro), #451 (Depakote), #489 (Ativan), #545 (Cogentin), #572, (Inderal), #606 (Luvox), #642 (Risperdal), #659 (Lunesta), #704 (Doxepin), #732 (Seroquel), and #799 (Abilify). In all cases, potential benefits of the medications were included as part of the medication plan. Similarly, informed consents (IC's) all contained key side effect information, and guardians were provided with more extensive monographs. The risk/benefit analysis was included as part of the MP. An example of a more detailed assessment for Individual #35 was: *"The Individual was taken off Abilify in 2010 due to stability of psychiatric symptoms. In the last 2-3 months, she has begun to exhibit severe agitation, hyperactivity, and restlessness accompanied with various disorganized behaviors, such as stuffing objects in her underwear and licking and smearing or wiping feces and body fluids on her body and other objects. She has become more resistant to redirection and shows increased anger and irritability. These behaviors impair her ability to participate in activities of daily living, programming and recreation. It also creates a significant health risk due to hygiene issues and increased risk of infections. Due to these concerns and previous history of stability on Abilify, her guardian, PCP, RN case manager and other IDT members agree for a re-trial of Abilify. Benefits of Abilify outweigh the associated risks/side effects due to expected improvement in the individual's psychiatric symptoms, quality of life and level of functioning."* In addition to discussion about risk and benefits, the Monitoring Team reviewed the new medication packages and the records for the presence of a presentation about treatment alternatives. These were rarely present. The Facility should consider the addition of an item about treatment alternatives, on the MP. Under the new system in use at the Facility medication plans are written annually, and then incorporated into the PBSP. When this is done, it would be useful for the psychiatrists to comment on risk benefit on the basis of the experience the individual has had with the medication to date. This was done in the example cited above, which is an example of good practice. <u>Discussion and documentation during psychiatry clinics:</u> A second level of review for Risk/Benefit was the quarterly medication review. The form used for the quarterly review had a section that reviewed the treatment plan and enquired about polypharmacy, medications dosed above the maximum dose guidelines,	

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<td>assessment of risk vs. benefit, treatment rationale, and alternative treatment strategies. During the clinics observed by the Monitoring Team there was general discussion on these topics, including treatment alternatives.

Generally, there has been improvement in the presentation of the risk/benefit analysis, for example by inclusion of the medication plan into the PBSP. However, additional attention should be paid to the inclusion of discussion about treatment alternatives, per the provision language. The provision is not in compliance due to the lack of discussions about treatment alternatives.</td>
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<td>J11</td>
<td>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.</td>
<td>At the time of the visit there were 241 individuals who were treated with psychotropics, and of these, 75 (31%) individuals were treated with some form of polypharmacy. The key place where polypharmacy was reviewed was at the Monthly Polypharmacy Review Committee. The meeting was attended by the Pharmacy Director, Medical Director, Lead and Staff Psychiatrists, Psychiatry Assistants, and Primary Care Providers.

The structure of the work of the Committee continued to be that individuals who received intra-class polypharmacy (currently 11 individuals) were reviewed monthly. The format was that attending psychiatrists were provided an update on an individual's 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, and so forth.

Periodically, the Committee also reviewed pharmacy data regarding Facility use of a medication or class of medication. Recent reviews have been for benzodiazepines and anticholinergic medications.

Data from the Committee showed continued reductions in polypharmacy, as illustrated by the following table:
<table>
<tr><td></td><td>12/08</td><td>12/09</td><td>12/10</td><td>12/11</td></tr>
<tr><td>Intra-class polypharmacy</td><td>24</td><td>21</td><td>18</td><td>12</td></tr>
<tr><td>Total of 3 psychotropics</td><td>56</td><td>53</td><td>50</td><td>46</td></tr>
<tr><td>Total of 4 psychotropics</td><td>34</td><td>26</td><td>17</td><td>15</td></tr>
<tr><td>Total of 5 psychotropics</td><td>13</td><td>8</td><td>5</td><td>2</td></tr>
</table>
</td>
<td>Substantial Compliance</td>
</tr>
</table>

		(*) 2012 data included the addition of 14 individuals who had Alzheimer's/acetylcholinesterase inhibitor medications and anticonvulsant polypharmacy. The monthly PRC took place during the visit of the Monitoring Team and was observed by the Monitoring Team. During the meeting the Pharmacy Director announced that the PRC had extended its review of medication classes to anticonvulsant and anticholinergic medications. This was a positive practice. Each month at PRC all individuals with intraclass polypharmacy were reviewed. Other groups (for example the group of individuals on four psychotropics) were reviewed on a rotating basis. The Facility provided an individual-by-individual table, which provided the treating psychiatrist's justification for the treatment regimen. Often, the psychiatrist provided his/her assessment of the individual's response to the particular medication. In the current report the Monitoring Team accepted the psychiatrist's conclusion, and did not review the record to verify that there was data to support the conclusion. The Facility should make sure that conclusions are adequately supported, since at the upcoming visit the Monitoring Team will verify that is the case. Polypharmacy was also reviewed at an individual level. The observations of the clinical pharmacist were part of the quarterly psychiatric review (QMR) through their QDRR reviews. Examples were: • Individual #505: The individual was treated with Risperdal and Depakote as well as a number of somatic medications. The pharmacist listed the individual as having polypharmacy; the pharmacist drew the team's attention to the individual's hospitalization for renal failure and recommended appropriate labs for monitoring. The psychiatrist responded with a note clarifying that the labs had already been ordered. • Individual #60: The individual was treated with four psychotropics. The pharmacist checked about possible drug-drug interactions but none were found. • Individual #321: The pharmacist clarified the manner in which concurrent administration of Olanzapine and Carbamazepine can increase anticholinergic activity and enhance adverse effects including tachycardia, urinary retention and constipation, among other side effects, and recommended continued monitoring for these symptoms. • Individual # 311: The individual was treated with psychiatric polypharmacy and the pharmacist commented on additive anticholinergic effects of Risperdal and Amantadine, both of which were appropriately prescribed by the psychiatrist. • Individual #183: The individual's complex needs - both neurological and psychiatric challenges- were discussed. The clinical pharmacist commented that enzyme induction by carbamazepine may increase Olanzapine clearance. The psychiatrist provided assurances that needed labs had been done.	

		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, 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. In the Self Assessment the facility reported that nurse case managers have been in-serviced to complete DISCUS and MOSES screens. The Monitoring Team reviewed details of training provided to RN case managers on DISCUS and MOSES screens, and reviewed the supporting materials provided to support the training. The content and length of the training sessions were appropriate and the background materials provided were the standard and accepted references for the material. Training for the side effect screening appeared appropriate. The Monitoring team reviewed the process followed by the Facility for side effect screening. The screening was done by nurse case managers who were familiar with the individual, and the same nurse case managers attended the psychiatry clinic appointments where the results of the screening were reviewed. The Monitoring Team attended psych clinics where screens were reviewed, along with other materials. Facility wide tracking for individuals with high DISCUS scores was reviewed and the Monitoring Team verified that once individuals were diagnosed with tardive dyskinesia, the diagnosis was entered into the record. The Lead Psychiatrist confirmed that the Polypharmacy Committee tracked individuals with known dyskinesia, to assure that proper caution was used regarding the use of these psychiatric medications with these individuals that could promote a process of further dyskinesia. The records of the 15 individuals in Sample #1 were reviewed for the presence of required screening. In 6 of 15 individuals, (40%), one or more of the screenings were not provided. To explore the possibility that the side effect screenings had been done but a copy of the document was not provided to the Monitoring Team, the Facility list of all recent evaluations was inspected. The missing screens were not listed on the document. One (Individual #287) was rated on 10/19/11 as having no dyskinesia, but on 1/10/12 the same individual was listed as having persistent dyskinesia. No problems were noted with missing signatures. One of the action steps for this provision on the 3/8/12 Facility Action Plan was to make	Noncompliance

		sure that RN case managers will have the side effect screens reviewed by both the psychiatrist and the primary care physician. There were no difficulties noted on the current visit on these items. However the number of screens that were needed but missing suggested that there was a breakdown in the system for tracking the need to complete the screen.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	The practice at the Facility was that the treating psychiatrist completed a one-page document called "Medication Plan (MP)" each time a new psychotropic medication was proposed. In addition, MPs for existing psychotropic medications were reviewed and updated as part of the annual psychiatric evaluation. The annual psychiatric review was typically completed just prior to annual ISP meetings, to ensure that up-to-date psychiatric information was included in the annual PBSPs and ISPs. 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 In the report for the third compliance visit, the Monitoring Team noted that the elements of the MP that had been developed by the Facility corresponded to requirements of provision J13. Accordingly, the Monitoring Team was able to state that the Facility had developed a credible method to respond to the requirements of the provision. The Monitoring Team also noted that implementation of the new process for medication plans was in its early stages. During the current compliance visit, the Monitoring Team reviewed the clinical records of 15 individuals. For purposes of review of this provision, the key items reviewed for each individual were MPs, PMRs and PBSPs. The reason for this was that MPs were implemented/tracked in the psychiatry clinic, and the integration of medication treatment with the overall behavioral health care program was recorded in the PBSP (see provision J3). Review of the records provided the following information: <u>Medication Plan Information</u> • <u>Information on medication and diagnosis:</u> MPs contained both the name of the	Noncompliance

		medication and the psychiatric diagnosis that was related to the medication. In most cases both were provided; when there was more than one diagnosis, the psychiatrist typically listed the diagnosis that was relevant to the medication named in the MP. • Rationale for the treatment: The purpose of this section was to clarify why the particular medication was proposed, in the context of the individual's overall treatment. In most cases, the rationale was appropriately presented with one or two sentences. On occasion, more thought should have been given to the rationale. For example, in the MP for Remeron for Individual #151, no rationale was provided. In the MP proposing Quetiapine for Individual #679 the diagnosis was OCD and the rationale was to address anxiety and restlessness. The association was not obvious and should have been explained. • Target psychiatric symptoms: The Monitoring Team examined the list of target symptoms to make sure that at least one of the targets 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 (29/34, 85%) the Monitoring Team found that the targets that were selected by the psychiatrist related to the diagnosis in question. In one occasion (Individual #679, for the medication Quetiapine,) the psychiatrist did not provide any target. • Symptoms to be monitored: DSSLC elected to base symptom rating on personal observations by the psychologist, supported by information provided to the psychologist by DCPs and other staff members. The Facility chose this system over alternatives such as the use of standardized rating scales, since the method allowed for the ratings to be tailored to the individual and his/her particular array of behaviorally observable symptoms. Sometimes, what was monitored required little or no clarification as for example, when a report on the number of hours of nighttime sleep was provided to help determine whether a hypnotic was effective in treating insomnia. Other times, however, there was a need to clarify the details of the monitoring. For example an individual could be medicated by the psychiatrist for anxiety and the psychologist and the IDT might determine that the best way to monitor the individual's level of anxiety in behaviorally observable terms would be observations of relevant "markers" of anxiety, such as the frequency of particular mannerisms, a measure of heart rate, or rate of behaviors associated with anxiety, such as pacing. The general thought was that in the IDT process, typically at the PMR, the psychiatrist would take the lead in suggesting the target symptom for a proposed medication treatment, and the psychologist would take the lead to suggest how that symptom would be best assessed. The Monitoring Team found evidence that this step in the process was lacking. In	

17 of 34 (50%) MPs that were reviewed, the Monitoring Team found that the MPs did not specify with clarity what the psychologist would monitor. As outlined below, the lack of clarity in the MPs about what would be monitored impacted negatively on the subsequent assessments that were made.

For example:

- Individual #746 was diagnosed with Cyclothymia and medicated with Depakote and the relevant psychiatric target was mood lability. The measures selected by the psychologist were "crying" and restless/agitated. The PMR reports data for these two measures on a scale of 1-3, but there is no way to know what a particular rating meant since the scale is not defined.
- Individual # 151 was diagnosed with Intermittent Explosive Disorder and was medicated with Geodon. One of the psychiatric targets was impulsivity, and the monitoring by the psychologist was for unprovoked rage. Both selections were reasonable, but what constituted "unprovoked anger" was not defined, nor were the ratings on the four-point scale defined.
- Individual #228 was diagnosed with bipolar disorder and was medicated with Risperdal. Target psychiatric symptoms included delusions and hallucinations. Monitoring was provided with a four-point scale, and relevant items were "imaginary people" and "anxious or irritable." Again, these were reasonable choices. However, it was unclear how the psychologist defined or rated "anxious or irritable" nor were the ratings on the four-point scale defined.

- Timeline for expected results: All medication plans had a timeline for expected results that was specified by the provision.
- Separate reporting of psychiatric data in PMR: Previous reports of the Monitoring Team had identified the need to differentiate between data collected on general behavioral targets. The Facility responded to the need to do so by changing the formatting of the PMR presentation to one that provided separate graphs for the two sets of data. In the large majority of cases the PMR reporting presented psychiatric and behavioral data separately. However, there were cases (for example Individual #732) for whom the psychiatric graph was blank (contained no data), and in some cases (for example, Individual #287) the PMR did not provide separate graphs for psychiatry and behavioral data.

The above analyses show that the medication plans were written for the psychotropic medications provided for each individual. In many cases, however, the tracking of the psychiatric symptoms by psychology needed to improve to match the symptoms identified as targets in medication plans. The same finding was noted by the Facility in its self-assessment. In the action plan for Provision J13, the Facility correctly identified that it

		needed continued improvement in documenting a clear rationale for the use of psychotropic medications in medication plans, in determining what data was tracked by the psychologists, and in assuring that the appropriate data was reviewed at psychiatric med reviews. Success in doing so will assure that the Facility will come into compliance.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	<u>Process in place for consent:</u> The process that was in place for preparing/reviewing the consent process was obtained and was reviewed with the Lead Psychiatrist. Non-emergency medications were discussed during PMRs/QPRs. Plans for use of the medications were developed, and discussions took place about risks and benefits, 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 was 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 J10). 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 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 together with the medication plan for the proposed psychotropic. The routine procedure was for the HRC and PBRC to review (1) the medication plan, (2) the IC , and (3) a revision of the PBSP that included the information on the new medication. <u>Contents of informed consent forms now in use:</u> The consent form now in use provided the following information: • Diagnosis • Medication for approval and medication dose ordered • Recommendations from consulting psychiatrist (if applicable) • 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 ISP. 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: • A description of any benefits to be expected • Disclosure of any appropriate alternative procedures that might be advantageous to the person served as well as the potential risks and benefits associated with	Noncompliance

		those alternatives • Possible adverse side effects/risk of the prescribed medication, per drug effect monographs provided to the guardian The Monitoring Team was informed that in all cases, the guardian or LAR was provided with a copy of the medication plan for the psychotropic medication in question. The document contained the following elements: • Medication name • Pertinent diagnosis • Rationale for treatment • Target psychiatric symptoms • Monitoring for treatment response 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 Monitoring Team requested information on all psychotropic medication approved by HRC and PBRC since the last compliance visit. Documents requested for each medication were the ICs, MPs , revised PBSPs, the HRC, and PBRC reviews for the new medications. These were received for the following individuals/medications: Individuals #34 (Abilify), #108 (Cymbalta), #158 (Remeron), #171 (Zyprexa), #194 (Prozac), #240 (Saphris), #247 (Trazodone), #306 (Cogentin), #397 (Lexapro), #451 (Depakote), #489 (Ativan), #545 (Cogentin), #572, (Inderal), #606 (Luvox), #642 (Risperdal), #659 (Lunesta), #704 (Doxepin), #732 (Seroquel), and #799 (Abilify). The Monitoring Team found evidence of progress on this provision. The current practice at the Facility is to revise the PBSP to include a copy of the new MP. That resolved the concerns the Monitoring Team had expressed about incorrect information on the medications being listed in the PBSPs. The Monitoring Team had also expressed concerns about the practice of listing a single list of side effects in the PBSP, for all medications. The inclusion of the MP into the revised PBSP resolved that issue too. The Monitoring Team reviewed a number of revised PBSPs that were written in the new format and that included MP information on the new medication. Examples were Individuals #451(Depakote) and #397 (Lexapro). However, in some cases revised PBSPs were not available and HRC review forms were not received. In the Self-Assessment for this provision the Facility acknowledged that there was sometimes an absence of all the required elements of informed consent.	
J15	Commencing within six months of the Effective Date hereof and with	Materials reviewed for assurance of compliance with provision J15 included a review of dual purpose anticonvulsant medications used (1) for psychiatric indications, (2) for	Substantial Compliance

	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.	neurological indications, and (3) dual purpose medications used for both psychiatric and neurological indications. The Monitoring Team reviewed the ongoing functions of the neuropsychiatry clinic with the nurse who coordinated the neurology clinic. No neurology- psychiatry clinic was scheduled during the visit of the Monitoring Team, so the clinic could not be observed. The Monitoring Team was told that the clinics continued to be held monthly, at the beginning of one of the scheduled on-site neurology clinics. The conference length varied but was typically about an hour. It was attended by the neurologist, one of the psychiatrists, the neurology clinic coordinator, and one of the psychiatry assistants. In addition to participation in the designated neurology-psychiatry clinic, 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 requested and was provided with the most recent notes for five individuals seen in clinic, all on 1/25/12. In each case the note addressed the consultation between the neurologist and psychiatrist regarding anticonvulsant medication use. In three of the cases the note documented the discussion between the neurologist and psychiatrist about the use of a medication used for both seizures and psychiatric disorder. These were Individuals #319, #255, and #60, all of whom received Depakote for a seizure disorder and a psychiatric disorder. In two cases, the individuals had been followed in the neurology clinic, and the need for continued anticonvulsant treatment for epilepsy was discussed. In one case (Individual #386) the diagnosis of epilepsy was questionable – there was only one documented seizure, in 2008, at a time of medication toxicity. The individual was also treated with Depakote for psychiatric symptoms. The consultation clarified that while Depakote continued to be needed, it was for psychiatric and not neurological reasons. Similarly, Individual #277 was prescribed Depakote as a dual purpose medication, but the review showed that the diagnosis of epilepsy was questionable and the individual had not had any seizures in a long time. The discussion between the neurologist and psychiatrist helped clarify that the medication was needed for psychiatric symptoms, but probably not for epilepsy. The discussion with the neurologist about the two medications was very helpful; it allowed the psychiatrist to prescribe the medication on the basis of the psychiatric symptom, without undue concern about ongoing seizures. On the basis of the discussion with the psychiatrists, the discussion with the clinic coordinator, and review of the relevant documents, 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. The section of the Medication Plan on the monitoring of target symptoms needs to provide more specific information on the monitoring process. If the psychologist will be rating particular symptoms or behavioral characteristics of the psychiatric disorder these should be listed and if necessary, defined, or guidance should be provided regarding where in the record that information can be found. (Provision J13).
2. Monitoring for psychiatric symptoms that is reported in PMRs and QMRs should be consistent with the MP for the relevant medication.
3. Descriptions in the record (PMR and elsewhere) of whether anticonvulsant medications are used for seizures, for a mental health disorder, or for both should be consistent with descriptions that are provided to, and tracked by, the pharmacy. The Monitoring Team encountered an example, where the PMR described the use of the anticonvulsant differently than was listed. f (Provision J3 and J15).
4. When psychiatric diagnoses are changed during the course of the year, the reason for change and the justification for the new diagnosis should be included in the annual psychiatric evaluation that follows. (Provisions J2 and J6).
5. When psychiatric diagnoses are changed during the course of the year, the APL in the record should be updated accordingly. (Provision J2)
6. Psychiatric Evaluations should be completed in a timely manner. (Provisions J2 and J6)

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 Self-Assessment 3/16/12 2. DSSLC Action Plan 3/8/12 3. DSSLC Presentation Book for Section K 4. Counseling Policies and Procedures (12/1/2010) 5. Positive Behavior Support Committee meeting minutes - 9/7/2011 – 2/22/2012 (24 meetings) 6. Behavior Service departmental meetings minutes – 12/9/2011 and 2/10/2012 7. Documents that were reviewed included the annual ISP, ISP updates, Skill Acquisition Plans (SAPs), 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 Self-Assessment and included Individuals #50, #108, #110, #132, #217, #229, #230, #231, #287, #306, #353, #476, #494, #605, #616, #629, #638, #686, #731, #790, #494, #629, and #731 **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. Dale Denney, M.Ed., LPC-S – Psychologist 6. Matt Grennell, MS, BCBA - Psychologist 7. Candy Mathers, MS – Psychologist 8. Robert Schecter, MS, LPC – Psychologist 9. Janet Waggoner, MS, LPC-I – Psychologist 10. Approximately 30 direct care staff in the following residences and day treatment areas: 505A, 506C, 508A, 508A, 509A, 522A, 522B, 522C, 522D, 522D, 523A, 523A, 523B, 525A, 525A, 525B, 525D, 526A, 526A, 526B, 526B, 526C, 527A, ICD 120, ICD 124, ICD 128 **Meeting Attended/Observations:** 1. Active Treatment Meeting – 4/5/2012 2. Human Rights Committee Meeting – 4/4/2012 3. Positive Behavior Support Committee – 4/5/2012 4. Restraint Reduction Committee – 4/4/2012 5. Observations were conducted in the following residences and day treatment areas: 505A, 506C, 508A, 508A, 509A, 522A, 522B, 522C, 522D, 522D, 523A, 523A, 523B, 525A, 525A, 525B, 525D, 526A, 526A, 526B, 526B, 526C, 527A, ICD 120, ICD 124, ICD 128
	Facility Self-Assessment:

	At the time of the site visit, DSSLC reported that Provisions K2, K3 and K8 were in substantial compliance with the SA. The Monitoring Team was in agreement with the Facility's assessment of Provisions K2 and K3. In regard to Provision K8, however, despite considerable progress by the Facility, additional work remained before substantial compliance could be achieved. The Facility provided two documents intended to present the status of current efforts to comply with Section K of the Settlement Agreement. The first document was a Self-Assessment that was to reflect the Facility's appraisal of progress toward compliance with the Settlement Agreement. The Section K Self-Assessment often presented both a quantitative and qualitative assessment of current conditions. For example, the section of the Self-Assessment pertaining to Provision K4 presented the percentage of items that were rated as in compliance, as well as the reasons why certain elements were not rated as in compliance. This approach to self-assessment helped to clarify the self-assessment ratings and provide emphasis upon those areas requiring additional effort. The second document was the Action Plan that outlined the steps the Facility had identified as critical to satisfying the Settlement Agreement. The Section K Action Plan lacked the focus and clarity of the Self-Assessment. Action steps were often non-specific. In addition, it was not specified how the evidence measures would successfully indicate progress toward substantial compliance. For example, one action step was defined as "Develop a DSP workgroup to assess most effective ways of collecting data" while the identified evidence for this action step was "Workgroup Meeting Minutes". Undoubtedly, a workgroup could prove beneficial in improving data collection methods and meeting meetings could document that process. What this action step lacked, however, was the means by which the workgroup would achieve the intended goal. A comprehensive Action Plan must consist of more than a series of steps. There must be an underlying understanding of specific needs as well as a precise, goal-directed approaching to addressing those needs. This process is very similar to the development of an individualized task analysis. At the time of the current site visit, however, the Action Plan presented for Section K lacked the necessary attention to specifics that would allow for substantial compliance with the Settlement Agreement.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at DSSLC from 4/2/2012 through 4/6/2012. Record reviews continued off-site following the site visit. Based upon information gathered during the current site visit, it was apparent that two Provisions of Section K, K2 and K3, were in substantial compliance with the Settlement Agreement. Throughout the current site visit, it was quite evident that the Facility had invested considerable effort into improving services. Substantial changes had been implemented in relation to several Provisions of Section K since the previous site visit. Some, but not all, of the changes had resulted in considerable progress. Perhaps most noteworthy were the broad and creative changes made in the approach to counseling services and the tracking of counseling data. Although additional work was necessary in a small number of areas, the Facility had developed an evidence-based model for counseling services in six months, as well as implemented the new model for all individuals who were receiving counseling. Substantial improvements had also been achieved in relation to PBSP data graphing and progress notes, although implementation was

	more limited. Improvements in functional assessments and PBSPs were also achieved, although the progress in this area was more subtle and evolutionary. Although substantial progress had been achieved in some areas, the Facility continued to struggle in relation to other Provisions of Section K. Considerable effort had been made in integrating behavioral and psychiatric assessments and treatments. This produced a document framework within which both disciplines could present assessment findings and combine intervention strategies. In many circumstances, however, the information regarding mental illness did not reflect the evidence-based process necessary to integrate with the behavioral model for assessment and treatment. Other areas also reflected a lack of progress, including the effective use of data in developing treatment decisions, the lack of reliability measure for treatment data, the limited use of treatment integrity measures, and the pervasive lack of intellectual and adaptive behavior assessments. It was evident that important and necessary changes had been implemented at DSSLC. Overall, however, the Facility continued to lack substantial compliance with the Settlement Agreement in all but two Provisions of Section K.

<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>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. In September 2011, data reflected that 21 of 121 PBSPs (17%) developed in the previous six months were developed by a BCBA.

At the time of the current site visit, DSSLC had implemented 348 PBSPs since the previous site visit (per report following the visit, these include all new plans and existing plans that had revisions that required new approval of the entire plan, such that the same plan may have been duplicated in this count). Of those PBSPs, 142 or 41% had been developed by a BCBA. This was an increase of 27% over baseline conditions and was greater than twice the percentage reported six months previously. Although not yet sufficient to achieve substantial compliance, the increase in PBSPs completed by a BCBA reflected considerable improvement by the Facility.

<table><tr><td></td><td>9/2010</td><td>9/2011</td><td>4/2012</td></tr><tr><td>Total number of PBSPs implemented since previous site visit</td><td>224</td><td>121</td><td>348</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>41%</td></tr></table>
DSSLC also demonstrated progress in increasing the number of staff who possessed</td><td>Noncompliance</td></tr>
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<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>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 22 staff eligible to pursue board certification, with 12 employees having earned board certification. Those 12 BCBAs comprised 55% of the department, an increase of 20%.

<table>
<tr><td></td><td>3/2010</td><td>9/2011</td><td>4/2012</td></tr>
<tr><td>Percent of staff who were BCBAs</td><td>24%</td><td>35%</td><td>55%</td></tr>
<tr><td>Percent of staff lacking BCBA who were pursuing board certification</td><td>23%</td><td>85%</td><td>90%</td></tr>
</table>

Of the 10 Behavior Service staff who were not board certified, 9 were actively participating in classes or supervision required for board certification. These data reflected that DSSLC had acted diligently and aggressively toward employing BCBAs. Despite the noted progress, however, DSSLC was not yet able 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. In January 2012, Mr. Spence Mr. Spence passed the exam for board certification in applied behavior analysis. This accomplishment by Mr. Spence satisfied the Provision K2 requirements for substantial compliance with the Settlement Agreement.</td><td>Substantial Compliance</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 who 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.</td><td>Substantial Compliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>External peer review included the use of a checklist that targeted 8 areas of competence: 1) Individual is fully described or identified, 2) Rationale for Positive Behavior Support, 3) Goal/Objective, 4) Functional Assessment, 5) Written PBSP, 6) Plan of Implementation, 7) Program Evaluation, and 8) Professional Integrity. Items in each of these areas were rated on a scale of zero (no evidence the task was performed) to three (Best Practice competence). An aggregate comparison of all PBSPs receiving external peer review during the past six months with those completed during the 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>Percentage Achieved 4/2012</th></tr>
<tr><td>Competency 1</td><td>78</td><td>88</td><td>90</td></tr>
<tr><td>Competency 2</td><td>50</td><td>72</td><td>82</td></tr>
<tr><td>Competency 3</td><td>75</td><td>87</td><td>91</td></tr>
<tr><td>Competency 4</td><td>52</td><td>80</td><td>90</td></tr>
<tr><td>Competency 5</td><td>51</td><td>76</td><td>92</td></tr>
<tr><td>Competency 6</td><td>35</td><td>42</td><td>96</td></tr>
<tr><td>Competency 7</td><td>33</td><td>63</td><td>91</td></tr>
<tr><td>Competency 8</td><td>78</td><td>93</td><td>95</td></tr>
<tr><td>Total of all Competencies</td><td>55</td><td>75</td><td>94</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</td><td>Considerable deficits were noted in the collection of behavior data during the initial 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.</td><td>Noncompliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.</td><td>In September 2011, observations and record reviews revealed substantial improvement in many areas over the baseline site visit. One area where data collection reflected substantial limitations, however, was in the graphic presentation of interobserver agreement (IOA) data: None of the data graphs reviewed included IOA data.

During the current site visit, the Facility reported that the data collection procedure had not changed since the previous site visit. It was reported, however, that substantial changes had been recently introduced to the data presentation and progress note format. These improvements included changes to the graphing process, increased use of phase-change lines and annotations, and the integration of psychiatric target symptom tracking. The Facility reported that the intent of the changes was to improve the ability to assess the response to treatment.

As the changes to the data graphs and progress notes were very recent, the sample of treatment records reviewed was limited to the eight individuals for whom the new process had been fully implemented. Based upon this limited sample, it was suggested that while DSSLC was improved in this area over baseline conditions, in comparison with more recent site visits there had been no progress. In several areas, the Facility had failed to maintain previous gains.

<table>
<tr><th></th><th>Baseline</th><th>9/2011</th><th>4/2012</th></tr>
<tr><td>Targeted behavior data collection sufficient to assess progress.</td><td>0%</td><td>82%</td><td>75%</td></tr>
<tr><td>Replacement behavior data collection sufficient to assess progress.</td><td>0%</td><td>73%</td><td>75%</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>50%</td></tr>
<tr><td>Targeted behaviors graphed sufficient for decision-making.</td><td>60%</td><td>82%</td><td>75%</td></tr>
<tr><td>Replacement behaviors graphed sufficient for decision-making.</td><td>0%</td><td>91%</td><td>75%</td></tr>
</table>

The revised format for the progress notes and data graphs reflected a notable improvement over previous documents. The materials were better organized and easier to navigate while allocating space for more information. When completed as designed, the new formats were likely to enhance the ability to identify the benefits of treatment and adequately guide the treatment monitoring process. Unfortunately, the progress notes and graphs submitted during the current site visit were not all completed with the attention to detail required for such documents. As a result, several areas of weakness</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		were noted. Data Reliability. One area in which no progress had been achieved over baseline conditions involved Interobserver Agreement (IOA) data collection and reporting. The Facility reported that procedures for IOA were undergoing revision and, therefore, very few IOA observations had been conducted. For some individuals, IOA was mentioned in the narrative of progress notes. In none of these examples, however, was the inclusion of IOA pertinent to the assessment of treatment response. • For Individual #50, the narrative of the progress note indicated that a single IOA observation had been conducted during the month. Data from this observation were not reported. • The progress note for Individual #686 presented that IOA observations had been attempted in the period covered by the note. No discussion was offered regarding the IOA data or the quality of the available data. Data Collection. The Facility had previously achieved substantial progress in relation to collection of target and replacement behavior data. No additional improvement was noted in this area during the current site visit. A variety of problems were documented in relation to data collection. • For Individual #605, staff submitted only 72% of the expected data collection forms from the previous month. For this same individual, data tables included in the progress note included several instances of missing data relating to psychiatric symptoms and behavior correlates. The missing data were not discussed in the progress note. • For Individual #132, only 72% of data collection forms were submitted by staff. Replacement behavior data were reported for only a single day during the month. Individually analyzed target behaviors. Only four of eight records (50%) reflected any attempt by the Facility to make distinctions between targets according to the origins of the behavior targeted or the potential function served by the target. Without this distinction, meaningful changes in behavior could be masked or skewed, rendering the determination of treatment benefits very difficult. Intervention targets and replacement behaviors graphed sufficiently for decisions. All progress notes reflected monthly graphs of data, which was sufficient for the targets monitored. For two of the eight PBSPs (25%) reviewed, the monthly graphs did not include all relevant targets. • Information pertaining to mental illness targets for Individual #731 was not integrated into the review process in the progress note.	

#	Provision	Assessment of Status	Compliance
		• For Individual #306, some targeted behaviors (i.e. "breathe") were not discussed in the narrative of the progress note or presented in the data graphs. The availability and presentation of treatment data are only one aspect of the process of monitoring the benefit of intervention plans and psychotropic medications. It is also necessary to conduct thorough reviews of the available data and to introduce changes in the treatment process when data indicate changes are necessary. The information submitted during the current site visit to DSSLC reflected that the Facility had achieved considerable progress in some areas. In other areas, however, it was evident that the Facility had not yet developed the practices necessary to ensure that all individuals received effective interventions.	

	1/2010	9/2011	4/2012
Graphed data are reviewed monthly or more frequently if needed, such as due to use of restraints or changes in risk level	0%	100%	100%
Review is conducted by a BCBA	0%	27%	50%
Input from direct care staff is solicited and documented	0%	0%	0%
Modifications to the PBSP reflect data-based decisions	0%	18%	38%
Criteria for revision are included in the PBSP	0%	0%	100%
Progress evident, or program modified in timely manner (3 Months)	0%	0%	38%

DSSLC demonstrated notable progress in relation to ensuring that treatment data were reviewed at least monthly. In addition, this review process was facilitated by the inclusion of criteria to guide the review process. All of the PBSPs that were reviewed during the site visit included specific and measurable criteria for treatment success, including timeframes within which treatment benefits were expected. In addition, 100% of reviewed PBSPs included a specific process to be followed when treatment response did not meet expectations. As a result of this progress, the Facility was much better prepared to provide an adequate review of behavioral and psychiatric interventions. Unfortunately, documentation revealed that these tools were not always used as intended and did not always result in treatment revision when revisions were indicated as necessary.

#	Provision	Assessment of Status	Compliance
		Data review is conducted by a BCBA. Documentation obtained during the current site visit revealed that treatment monitoring was conducted by a BCBA for 50% of the PBSPs in the sample. This reflected an improvement over baseline, as well as in comparison with the previous site visit The monthly progress notes and data graphs completed by BCBAs were substantially more detailed than those produced by non-BCBA staff, included fewer errors, and provided a more thorough discussion of treatment issues, such as the integration of behavioral and psychiatric modalities. The inclusion of a BCBA in the review of treatment did not, however, ensure that treatment decisions reflected adherence to evidence-based practices. In at least half of the PBSPs in which a BCBA participated in the monthly review, the data and progress notes reflected that poor response to treatment was not addressed or used as a basis for recommending revisions to the treatment plan Input from direct care staff. Nowhere in the available records was it presented that direct care staff were offered the opportunity or participated in the review of treatment data for any of the 8 PBSPs. PBSPs reflect data-based decisions. For three of the eight records reviewed (38%), there were indications that treatment decisions were based upon available data. In the remaining records, either no changes in the PBSP were attempted despite indications of poor program efficacy, or reviews of the PBSP only coincided with the annual ISP. • For Individual#132, there were no indications that behavioral or psychotropic interventions had provided meaningful changes in behavior. It was possible that treatment responses were masked by poor data collection. No discussion of data limitations was noted in the documentation and there was no indication that the poor response to treatment had been investigated. Timely revision of PBSPs. Of the 8 PBSPs reviewed, only three (38%) reflected either appropriate revisions following increases in treatment targets or an adequate response to treatment that negated the need for any revision. For the remaining 5 PBSPs (62%), poor treatment response did not result in a change in the PBSP.	

	BCBA Review	Non-BCBA Review
Modifications to the PBSP reflect data-based decisions	50%	25%
Criteria for revision are included in the PBSP	100%	100%
Progress evident, or program modified in timely manner (3 Months)	50%	25%

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
Individual #50 experienced an increase in insomnia in July 2011 that continued for several months. Verbally disruptive behavior, as well as aggression against people and property, increased in October of 2011 and remained elevated for several months. Neither progress notes nor treatment documentation reflected any attempt to revise the PBSP or psychotropic medication regimen during the noted increases in behaviors and symptoms.
It was evident during the site visit that effort had been made to improve behavior data and the use of data in the treatment monitoring process. 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 plays 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 provides insight into the current cognitive and adaptive abilities of the individual, and may provide 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>4/2012</th></tr>
<tr><td>A Psychological Assessment had been completed.</td><td>0%</td><td>91%</td></tr>
<tr><td>The Psychological Assessment was less than one year old</td><td>0%</td><td>65%</td></tr>
<tr><td>The Psychological Assessments contained findings from an intellectual test administered within the previous five years.</td><td>0%</td><td>0%</td></tr>
<tr><td>The Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.</td><td>9%</td><td>0%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Specific examples of weaknesses in the integration of intellectual and adaptive assessment are presented below. These are examples of outdated testing; if information is not current and accurate, it cannot be usefully integrated into planning of supports and services. • For Individual #731, the most recent Intellectual testing was completed in 1984. The most recent adaptive testing was completed in 1987. • For Individual #217, the most recent intellectual and adaptive assessments were completed in 1994. Routine assessment of intellectual and adaptive abilities is an integral part of developing a comprehensive perspective of any individual. In some cases, however, the availability of such assessment results can play a critical role in determining the extent to which health conditions and traumatic events have affected a person. In circumstances in which a person is experiencing a neurological disorder, prior intellectual and adaptive assessment may provide crucial insight into the impairment experienced by the individual, as well as the degree of recovery or decline that they have experienced. Documentation provided during the current site visit revealed circumstances in which individuals living at DSSLC experienced health problems involving cognitive and adaptive impairment, and for whom no routine assessment of those abilities had been provided. • Individual #132 was identified as showing signs of dementia. This individual had not received intellectual assessment since 1987 and had been provided no adaptive behavior assessment since 1993. Current intellectual and adaptive assessments could have helped in identifying specific areas of decline and focusing efforts to maintain skills and abilities. • Individual #353 experienced a stroke in late 2011. This individual had not received intellectual testing since 1984 and had not been provided adaptive behavior assessment since 1987. Current intellectual and adaptive assessments could have assisted in identifying the skills and abilities most affected by the stroke. The assessment of behavioral function is an essential component of effective behavior change and requires more than the completion of a screening tool, interview or series of observations. Determining the function of a behavior is an empirical process that begins with general observation and progresses with increasing control and focus through screenings, interviews and formal observations until a specific hypothesis regarding the function or purpose of the undesired behavior is developed. An acceptable functional assessment or functional analysis does not produce a series of ambiguous statements regarding the function of the undesired behavior. Rather, the product of the assessment process is a specific statement regarding the most likely function of the behavior or an	

#	Provision	Assessment of Status	Compliance
		indication of how ambiguous findings will be resolved. Without additional investigation, ambiguous statements are indicative of an assessment process that has not been completed. In late 2011 and early 2012, DSSLC began a review of functional assessment procedures. The goal was to refine the current functional assessment and to better integrate the process of psychiatric assessment into the development of PBSPs. A revised functional assessment format was finalized shortly before the current DSSLC site visit. Due to the recent nature of the revision, only five functional assessments had been completed using the new format. These five functional assessments comprised the sample of functional assessments for the current site visit.	

	1/2010	9/2011	4/2012
Assessment or review of biological, physical, and medical status	0%	67%	100%
Review of personal history	0%	83%	100%
A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis	0%	83%	100%
The process or tool utilizes both direct and indirect measures	0%	83%	100%
Identification of setting events and motivating operations relevant to the undesired behavior	0%	83%	100%
Identification of antecedents relevant to the undesired behavior	0%	83%	100%
Identification of consequences relevant to the undesired behavior	0%	83%	100%
Identification of functions relevant to the undesired behavior	0%	83%	100%
Summary statement identifying the variable or variables maintaining the target behavior	0%	67%	100%
Identification of functionally equivalent replacement behaviors relevant to the undesired behavior	0%	17%	100%
Identification of preferences and reinforcers	0%	17%	20%

#	Provision	Assessment of Status	Compliance
		Based upon a review of the five functional assessments, it was evident that considerable improvement had been achieved by DSSLC. The new format expanded the sections for reporting various aspects of behavior and allowed for a more comprehensive presentation of findings. Furthermore, the information provided about learned and environmentally-based behavior was presented in a coherent manner, followed accepted practices in applied behavior analysis, and provided an adequate foundation for the development of a PBSP. The one area related to learned behavior in the functional assessment that reflected substantial weaknesses related to the identification of reinforcers and preferences. Only one of the five functional assessments included a formal reinforcer/preference assessment. The remainder of the functional assessments included only anecdotal information about general likes and dislikes of the person whose behavior was being assessed. 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. The latest revision of the functional assessment implemented by DSSLC was a substantial improvement in both format and content. In order to assess compliance with the Settlement Agreement, it will be necessary for the Facility to complete, and for the Monitoring Team to review, a considerably larger sample than was available during the most recent site visit. 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. It is crucial, therefore, that the behavior assessment process be sufficient to identify the interrelationships between the biological conditions, the environmental contingencies, and the behaviors that are displayed. Once identified, it is then possible for the psychologist or behavior analyst and psychiatrist to collaborate upon identifying the appropriate treatment targets, selecting the appropriate psychotropic and behavioral interventions, and developing a strategy for tracking the efficacy of the interventions. During the September 2010 site visit, DSSLC demonstrated considerable difficulty in incorporating the behaviors associated with a mental illness into the functional assessment process. Improvement was noted March 2011, but in most cases functional assessments did not effectively identify the relationships between mental illness, the environment, and undesired behavior. Although considerable effort by DSSLC to resolve	

#	Provision	Assessment of Status	Compliance
		the weakness was noted during the September 2011 site visit, the sample of functional assessments did not reflect substantial improvement. As presented previously in this Provision, DSSLC had revised and implemented the format for the functional assessment prior to the current site visit. Much of the revision addressed limitations in the integration of mental health assessment with the assessment of environmentally-based behaviors. Although some of the mental health assessment was presented in the PBSP, the process was appropriately focused upon assessment and the integration between psychological and psychiatric services. Based upon the five functional assessments included in the Monitor's review, the following conditions were noted.	

	3/2010	9/2011	4/2012
The assessment process included screening for psychopathology, emotional, and behavioral issues.	0%	17%	40%
The assessment process included differentiation between learned and biologically based behaviors.	0%	17%	40%
Identification of behavioral indices of psychopathology	0%	0%	40%
Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities	0%	17%	60%

The assessment and treatment of mental illness in people with concomitant intellectual or developmental disabilities requires a carefully coordinated approach. In many cases, limited expressive communication skills or other aspects of the developmental or intellectual disability can mask symptoms of mental illness. In addition, undesired behaviors may reflect the symptoms of mental illness as well as learned responses to environmental stimuli. Finally, knowledge of the characteristics and symptomatology reflected in a specific diagnosis may make the process of identification of function and of potential reinforcers more efficient as it points toward specific directions. 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 new functional assessment format, and corresponding sections in the PBSP, provided an adept framework for the integration of assessment information. A format, however, is only one element in the actual integration of assessments. For true integration, there must also be an assessment process that reflects evidence-based

#	Provision	Assessment of Status	Compliance
		procedures and conforms to accepted standards of practice. Other than the assessment of preferences and reinforcers, the behavior assessment element of the functional assessments reviewed reflected both competence and diligence in meeting these goals. The assessment of mental health issues, however, did not consistently meet these expectations. Too often, the mental health assessments lacked observable and measureable targets, were not based upon objective assessments, and did not contribute to the understanding of the mental disorder or the behaviors that were attributed to those disorders. One example of these limitations involved Individual #217. The functional assessment reflected direct and indirect assessment of physical aggression. Food and attention were identified as the two consequences maintaining the targeted physical aggression, and a hypothesis of function was presented. The information provided in the psychiatric assessment did not reflect a comparable process. Discussion presented descriptive, anecdotal information and a statement of the diagnosis. No formal, objective assessment process was included and no data were presented to support the involvement of a mental illness. There was discussion of the general poor response to psychotropic medication, but no indications were provided as to why psychotropic medications were expected to provide benefit. A second example involved Individual #731. The functional assessment involved both direct and indirect procedures. Two target behaviors were identified, manual stimulation by the individual of their face that at times produced slapping and disruptive behavior that involved lying on the floor or kicking out with his legs. The function of the latter behavior was associated with escape from demands while the former behavior appeared to have an internal function although a motoric disorder was not ruled out. The psychiatric case formulation did not describe any assessment process. The probable etiology of mental retardation was presented, the current psychotropic drug regimen was described, and existence of Tardive Dyskinesia (TD) was discussed. The targets of psychotropic drug therapy included mood lability, impulsivity, anxiety, irritability, and aberrant movements, although there was no information provided about how to track these targets. Neither was there a rationale presented as to why an antipsychotic medication with potentially severe side effects was warranted given the nature of the targeted behaviors and the presence of Tardive Dyskinesia. The current functional assessment format used at DSSLC provided a comprehensive framework within which an integrated approach to behavior and mental health treatment could be developed. Although the small sample available for the new format limited interpretation, it was difficult to identify any areas or issues not included in the document. Nevertheless, a tool or assessment is only as strong as the information that it contains. The psychiatric assessment information included in the new format did not	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>provide information in a way that would most effectively support use of that information in identifying function.

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.</td><td></td></tr>
<tr><td>K6</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.</td><td>Based upon the information presented in Provision K5, the functional assessments completed by the psychology staff were considerably improved over previous site visits. Minimal documentation in the record, however, reflected that intellectual, adaptive behavior, or mental illness assessments were current, accurate, or complete.</td><td>Noncompliance</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>4/2012</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></tr><tr><td>For newly admitted individuals, psychological assessments are conducted within one month.</td><td>0%</td><td>100%</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.</td><td>DSSLC completed and implemented Counseling Policies and Procedures on 12/01/2010. These policies provided the necessary structure for counseling practices. During the September 2011 site visit, it was evident that considerable effort had been invested in the provision of counseling services. At that time, however, the counseling services offered at DSSLC did not provide an evidence-based approach to treatment. Treatment</td><td>Noncompliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.</td><td>goals and initial assessments lacked objective and measurable treatment expectations. In addition, counseling notes lacked specific data and were often subjective opinions of poorly defined behaviors.

At the time of the current site visit, DSSLC reported that 23 individuals were receiving counseling through the Behavior Services department at DSSLC. In order to assess the status of counseling interventions, a sample of the ten most recent counseling plans (43%) was selected for review.

<table>
<tr><th></th><th>1/2010</th><th>9/2011</th><th>4/2012</th></tr>
<tr><td>Needed services 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>Service/treatment plan includes initial analysis of problem or intervention target, and a plan of service (e.g., curriculum or approach, frequency or planned number of sessions, statement of skill or intervention target)</td><td>0%</td><td>0%</td><td>100%</td></tr>
<tr><td>Services are goal directed with measurable objectives and treatment expectations.</td><td>0%</td><td>0%</td><td>100%</td></tr>
<tr><td>Services reflect evidence-based practices.</td><td>0%</td><td>0%</td><td>100%</td></tr>
<tr><td>Services include documentation and review of progress. If service includes individual or group sessions, progress review includes note in record, or specific data for each session.</td><td>0%</td><td>0%</td><td>100%</td></tr>
<tr><td>Service plan includes “fail criteria”—criteria, such as lack of progress on objectives, or number of sessions without meeting the learning goal that will trigger review and revision of intervention.</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>
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#	Provision	Assessment of Status	Compliance

Service plan includes process to generalize skills learned or intervention techniques to living, work, leisure, and other settings, including homework or staff training as appropriate.	0%	0%	0%
Service identified in ISP and, if applicable, PBSP.	0%	0%	100%
Staff who provide therapeutic interventions are qualified to do so through specialized training, certification, or supervised practice.	0%	0%	100%
Staff who assist in therapy, 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 four Behavior Services personnel, the Facility had achieved extensive progress in addressing the weaknesses identified during the previous site visit. The entire process of providing counseling had been redesigned to reflect an evidence-based approach to intervention. The assessment process included the identification of specific treatment targets, provided an observable and measureable definition for each target, and specified a process for objectively tracking changes in those targets. Data were collected during each counseling session in addition to a narrative description of the session, and all data were entered into a comprehensive Microsoft Excel template for review and graphing. Where appropriate, the data from counseling interventions were integrated with behavioral intervention data and provided a broader insight into the individual and the treatment regimen.

One example of the revised counseling process involved Individual #110. For several sessions, the individual had been improving in relation to the treatment targets that included positive and negative statements, references to future plans, and demonstrations of targeted coping strategies. In addition, the individual's involvement in homework and workbook tasks had steadily improved. After approximately 18 sessions, the individual exhibited a substantial decline in participation and success that persisted for several sessions. Upon review of the data and discussions with the individual, changes in the treatment modality that had been introduced at the time of session 18 were identified as a source of dissatisfaction. Upon a return to the original treatment modality, the individual demonstrated substantial improvement and progress returned

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>to the patterns observed prior to the treatment change. Although not intentional, these events validated the counseling plan through a modified treatment reversal design.

Despite the progress achieved in counseling interventions, two areas were not adequately addressed. The first of these involved the lack of “fail criteria”, the establishing of specific data thresholds that would indicate a substantial lack of progress and require a review of the treatment plan. The example with Individual #110 illustrated the manner in which fail criteria should work. In that example, however, there were no actual criteria for review and the plan included no specific strategy for addressing such circumstances.

A second limitation in the counseling interventions involved strategies that would encourage generalization of new skills into new settings or circumstances. Although in some instances it appeared that efforts to generalize skills had been attempted, none of the counseling plans that were reviewed included specific strategies for generalization.

Overall, the information obtained and records reviewed during the current site visit reflected considerable progress toward substantial compliance with the Settlement Agreement.</td><td></td></tr>
<tr><td>K9</td><td>By six weeks from the date of the individual’s assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.</td><td>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. These weaknesses included the lack of accepted practices relating to anecdotal and formal functional assessments.

Beginning in late 2010 and continuing into early 2012, DSSLC had engaged in continual overhaul of the behavior assessment and intervention process. Due to this ongoing process, there were often few PBSPs to review during a site visit that reflected the current iteration of the PBSP. This was again true at the time of the current site visit, as PBSP revision had been recently implemented. As a result, only five PBSPs were available for review. Based upon observations and a review of those five PBSPs, the following trends were identified.

<table>
<tr><td>PBSP Element</td><td>Baseline</td><td>9/2011</td><td>4/2012</td></tr>
<tr><td>Rationale for selection of the proposed intervention.</td><td>50%</td><td>83%</td><td>100%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status				Compliance
		History of prior intervention strategies and outcomes.	50%	100%	100%	
		Consideration of medical, psychiatric and healthcare issues.	40%	40%	100%	
		Operational definitions of target behaviors.	70%	51%	100%	
		Operational definitions of replacement behaviors.	70%	51%	100%	
		Description of potential function(s) of behavior.	30%	67%	100%	
		Use of positive reinforcement sufficient for strengthening desired behavior	10%	17%	0%	
		Strategies addressing setting event and motivating operation issues.	60%	83%	100%	
		Strategies addressing antecedent issues.	60%	83%	100%	
		Strategies that include the teaching of desired replacement behaviors.	10%	17%	100%	
		Strategies to weaken undesired behavior.	30%	30%	100%	
		Description of data collection procedures.	20%	100%	100%	
		Baseline or comparison data.	0%	67%	80%	
		Treatment expectations and timeframes written in objective, observable, and measureable terms.	0%	0%	100%	
		Clear, simple, precise interventions for responding to the behavior when it occurs.	30%	0%	100%	
		Plan, or considerations, to reduce intensity of intervention, if applicable.	0%	67%	100%	
		Signature of individual responsible for developing the PBSP.	90%	100%	100%	
		In only one area were substantial limitations revealed in the PBSPs. None of the PBSPs included the use of reinforcers with sufficient strength to strengthen desired behavior or replacement behavior. In all of these PBSPs, some form of consequence was delivered with the intent of strengthening behavior. For none of these individuals, however, had a formal reinforcer or preference assessment been conducted. Instead of a formal				

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>assessment, anecdotal information provided by staff was used to guide the reinforcer selection process. For the majority of PBSPs, verbal praise was the reinforcer implemented to strengthen behavior. It was possible that for some of the individuals, verbal praise was able to strengthen behavior. Without a formal assessment, however, that could not have been known prior to PBSP implementation.

Based upon the review of the most recent PBSPs, it did appear that improvement had been achieved in many areas. This improvement, however, involved only five PBSPs, a very small percentage of the total number of PBSPs developed and implemented at DSSLC. As a result, there was not yet sufficient evidence to support a determination that progress toward substantial compliance with the Settlement Agreement had been achieved. During the next site visit, a more extensive sample of PBSPs will be selected.</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>During the current site visit, the Facility reported that the data collection procedure had not changed since the previous site visit. It was reported, however, that substantial changes had been recently introduced to the data presentation and progress note format. These improvements included changes to the graphing process, increased use of phase-change lines and annotations, and the integration of psychiatric target symptom tracking. The Facility reported that the intent of the changes was to improve the ability to assess the response to treatment.

As the changes to the data graphs were very recent, the sample of treatment records reviewed was limited to eight individuals. Based upon this limited sample, it was suggested that DSSLC had achieved improvement in this area.

<table>
<tr><th>Graph Element</th><th>Baseline</th><th>9/2011</th><th>4/2012</th></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>100%</td><td>70%</td><td>100%</td></tr>
<tr><td>Horizontal axis and label</td><td>100%</td><td>100%</td><td>80%</td></tr>
<tr><td>Vertical axis and label</td><td>0%</td><td>40%</td><td>100%</td></tr>
<tr><td>Condition change lines</td><td>0%</td><td>20%</td><td>80%</td></tr>
<tr><td>Condition labels</td><td>0%</td><td>20%</td><td>80%</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>
<tr><td>Demarcation of changes in medication, health status or other events</td><td>0%</td><td>30%</td><td>80%</td></tr>
</table>

Based upon the review of the PBSPs and data graphs, it did appear that improvement had been achieved in many areas. This improvement, however, involved only eight PBSPs, a very small percentage of the total number of PBSPs developed and implemented at</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		DSSLC. As a result, there was not yet sufficient evidence to support a determination that progress toward substantial compliance with the Settlement Agreement had been achieved. DSSLC had yet to implement a comprehensive system for measuring IOA. Although isolated instances of IOA were being conducted, the process was neither extensive nor consistent enough to allow for a review. The lack of a IOA process prevented the Facility from determining the reliability of behavior data. Furthermore, without IOA data, there was nothing to report regarding IOA on the data graphs. Although DSSLC had greatly improved the quality of the data graphs, it was not evident, as presented in Provision K5, that these data graphs were consistently and effectively used to formulate treatment decisions. In only three of the eight records included in the sample, were decisions to either continue or revise PBSPs and psychotropic drug interventions supported by the available data. In the majority of records, the progress notes and data indicated that no review or revision of the PBSP had been conducted despite indications that the current interventions were ineffective. Furthermore, several records reflected that individuals experienced increases in problem behaviors or indicators of mental illness for several months without a response from the IDT. Prompt and effective use of data graphs will be necessary before substantial compliance can be achieved by DSSLC.	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	In an attempt to ensure that all PBSPs are easily read and interpreted by staff, DSSLC required that the staff instructions section of each PBSP be written in 5th to 6th grade English. To ensure this requirement was met, PBSPs were not granted final approval by the peer review committee until software for determining readability had shown this goal to be achieved. To determine whether PBSPs were written so that staff was able to easily read procedures, 20 direct care staff were interviewed during the site visit. These staff were asked if PBSPs were easy to read and if staff were provided with adequate PBSP training. In addition, each staff was asked to describe a PBSP for an individual with whom they were familiar. All staff interviewed initially reported that PBSPs were easy to read and implement. As the interviews progressed, however, it became evident that many staff were not familiar with PBSPs or general behavior interventions. Furthermore, it was not uncommon for staff to display difficulty in describing the implementation of a PBSP even when they had the PBSP as a reference. As the interviews were unstructured, staff often offered comments unrelated to readability. Examples of comments and trends are reported below.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Two staff were unable to differentiate between PBSPs and SAPS until offered several prompts. • Staff frequently reported that PBSPs were "Too technical" or difficult to read quickly. • Several staff commented that PBSPs changed too often. • One staff member reported that they did not work with any individuals that required a PBSP. Two individuals in the staff's immediate vicinity were later identified as having PBSPs. Requiring that PBSPs be written using accessible language was a good initial effort by DSSLC. In order to progress toward substantial compliance; however, the Facility must ensure that staff not only find the PBSPs easy to read but also can demonstrate the ability to both access and implement intervention plans.	
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 12 staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 43 individuals residing at the Facility and fell 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 each available position be filled by a BCBA credentialed employee, DSSLC would achieve approximately a 1:23 ratio. The Facility also employs sufficient Psychology Assistants to provide one Psychology Assistant for every two full-time psychologists.	Noncompliance

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

1. The Facility must act to ensure the full assessment of the integrity and reliability of treatment data. (Provisions K4 and K10)
2. Efforts must be made to ensure data collection is consistently conducted according to the instructions provided in the PBSPs. (Provision K4)
3. A system should be developed and implemented to ensure that progress reviews for PBSPs are based upon individual treatment targets or groups of targets that serve the same purpose or function. (Provision K4)
4. Data graphs should include all intervention targets identified in the PBSP and assessment process. (Provision K4)

5. The participation of DCP staff in the review of treatment data, as well as documentation of that participation, must be consistently conducted. (Provision K4) 6. Treatments decisions must be supported by the available treatment data. Furthermore, data suggesting poor treatment response must be promptly addressed by the IDT. (Provision K4) 7. The Facility must act to increase the provision of intellectual and adaptive behavior assessments for people living at the Facility, as well as those people who have recently been admitted. (Provision K5) 8. A system must be put into place that ensures the assessment of mental illness reflects evidence-based practices and that mental illness assessments are fully integrated with assessments of learned and environmentally-maintained behaviors. (Provision K5) 9. Counseling programs should be expanded to include efforts to generalize progress to other settings and circumstances. (Provision K8) 10. Formal assessment of preferences and reinforcers should be integrated into the functional assessment process. (Provision K9) 11. Systematic efforts to ensure that staff is competent in the implementation of PBSPs must be implemented throughout treatment settings at DSSLC. (Provision K11)

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. DSSLC Self-Assessment 3/16/12 2. DSSLC Action Plan 3/8/12 3. Denton Presentation Book for Section L 4. DSSLC Medical Policy 009.2, not dated, in draft form 5. Osteoporosis Guidelines for the PCP, undated 6. Annual physical exam, personal support plan (ISP), medication list, 12 months laboratory studies, DEXA report for Individuals #461, #66, #205, #737, #139, #520, #710, #244, #3, #362, #787, #247, #289, and #769 7. Annual physical exam, ISP, physical therapy assessments (PT/OT), 12 months labs, and imaging reports for Individuals #560, #637, #272, #345, #503, #423, #18, #82, #402, and #320 8. The most recent hospitalization reports for Individuals #351, #337, #114, #5, #198, #32, #750, #526, #292, and #19, including copies of the hospital admission and discharge reports, hospital liaison notes, interdisciplinary team meeting notes, and the physician documentation demonstrating appropriate clinical follow-up 9. Most recent medical quarterly review, annual medical summary, and active problem list for Individuals #55, #373, #698, #183, #669, #167, #334, #196, #232, #240, #565, #308, #14, #191, and #306 10. The most recent two annual medical summaries and physical examination evaluations for Individuals #105, #197, #276, #537, #759, #594, #275, #4, #191, #13, #177, #571, #606, #726, and #228 11. List of current clinician staff, along with CME and CPR certificates 12. Most recent two IPN notes for each practicing clinician 13. Active clinical records for Individuals #105, #197, #276, #537, #759, #594, #275, #4, #191, #13, #177, #571, #606, #726, and #228 14. Hospitalization and related records for Individuals #351, #337, #114, #5, #198, #32, #750, #526, #292, and #19 15. Randomly generated list of 20 individuals from the Facility roster, and their most recent hearing, vision

	and immunization records 16. Randomly generated list of 20 individuals from the Facility roster of males over the age of 50 and their most recent PSA result 17. Randomly generated list of 20 female individuals over the age of 40 years old from the Facility roster, and their mammogram results 18. Randomly generated list of individuals over the age of 40 from the Facility roster, and their most recent colonoscopy report, or documentation providing rationale why they did not undergo a colonoscopy 19. Most recent bone density report, medication list, physician notes and labs for Individuals #461, #66, #205, #737, #139, #520, #710, #244, #3, #362, #787, #247, #289, and #769 20. Annual medical assessment, ISP, PT/OT report, and 12 months labs for Individuals #560, #637, #272, #345, #503, #423, #18, #82, #402, and #320 21. List of all individual who had a DNR order, and the clinical rationale for the DNR, and type of DNR 22. List of last 10 individuals who were hospitalized for pneumonia, and their hospital admission and discharge record, PNMT reports, and Doc-to-Doc physician note 23. List of all individuals who sustained a fracture during the review period, and associated medical records, and PNMT reports 24. Most recent annual medical summaries, past 12 months labs, consultation reports, and all physician notes specific to PKU for Individuals #556, #205, #33, #517, and #787 25. Active clinical record for Individual #392 26. Past 12 months medical assessments, PT/OT assessments, ISPs, medication list, labs, MOSES and DISCUS, and all physician notes and consultation reports specific to the management of spasticity, and abnormal movements for Individual #118 27. Most recent two nursing assessments, past 12 months medical assessments, physician notes, PT/OT assessments, and most recent medication list and all consult reports and physician assessments for the management of spasticity for Individual #571 28. Active clinical record for Individual #715 29. Internal and External Physician Audits for February 2012 30. Summary report, and action steps for February 2012 External Physician Audits 31. Physician audit tools for diabetes, seizure disorder, urinary tract infection, osteoporosis, and constipation 32. Clinical pathways for seizure disorder, diabetes, and osteoporosis 33. DSSLC Clinical Death Review Policies and Procedure Manual, Committees and Councils – 07A, Date: May 15, 2006 34. DSSLC Administrative Death Review Committee, Policies and Procedure Manual, Committees and Councils – 07B, Date: May 1, 2006 35. DSSLC Clinical and Administrative Death Review Tracking Log, 9/2011 through 3/2012 36. DSSLC Clinical and Administrative Death Review Recommendation Tracking Logs, 9/2011 through 3/2012 37. DSSLC Unusual Incident Investigation Reports for Deaths of Individuals: #621, #356, #601, #234, #730, #701, #74, and #524 38. Department of State Health Services – Vital Statistics Unit, Death Certificates for Individuals: #504, #621, #356, #601, #234, #419, #730, #701, #74, and #524

	People Interviewed: 1. Steven Kubala MD, Medical Director 2. Johanna Hayse, RN, Wound care Nurse 3. Delia Shider, RN, CNE 4. Sibylle Graviett, Nurse Case Manager Supervisor 5. Maria T. Pangilinan, RN, Infection Control Preventionist 6. Connie Horton, RN, FNP, State Office Consultant 7. Valerie Kipfer, MSN, RN 8. James W. Galbreith, M.D **Meeting Attended/Observations:** 1. Observed individuals at homes Cedar Falls A, B, C, and D; Pine Ridge B; Garden Ridge C 2. Observed individuals a Cedar Falls Day Training Programs 3. Delia Schilder, RN, Chief Nurse Executive (CNE) 4. Sherri Courtney, RN, Nursing Operations Officer (NOO) 5. Laura Stoffels, RN, Nurse Investigator 6. Valerie Kipfer, RN, State Office Nursing Coordinator
	Facility Self-Assessment: The Facility's Self-Assessment (SA) and Action Plans were reviewed, and the Monitoring Team concurs with the Facility's assessment of non-compliance with Provisions L.1 through L.4. The self-assessment for Provision L.1, was correct in determining that the Facility required further improvement in quality assurance audit systems, and timeliness of completing medical assessments. Medical Audits, however, belongs to Provision L.2 and not Provision L.1. The self-assessment did not comment on the quality of the provision of medical services. The Monitoring Team does agree, however, that a functional QA process for medical services would enable assessment of clinical services. The Monitoring Team concurs with the self-assessment for Provisions L.2, and L.3, which reports that in order to determine compliance for Provision L.2, a new tracking system would be necessary to assess the effectiveness of the new medical audits. The Monitoring Team strongly agrees with the self-assessment for Provision L.4, which states that additional policy and clinical pathways need to be developed.
	Summary of Monitor's Assessment: The Monitoring Team would like to compliment the Facility and physician services for their dedication and hard work to enhancing medical services at the Facility. It was most obvious during this review that many of the new procedures, and practice standards are starting to be implemented. Despite non-compliance, Medical Services is clearly heading in the right direction, and the quality of medical care has significantly improved. It should be noted that the Facility had significant turnover of clinicians during the past six-month period, resulted in delays in fully implementing new procedures. The following is a summary of each provision reviewed for Provision L: Provision L1. Following its review, the Monitoring Team noted many positive findings, such as significant

	improvement of medical assessments by the clinician, and improved Integrated Progress Notes (IPNs) that are more comprehensive and include an assessment and plan, in most cases. Assessments tend to be done timely, and are legible. Review of clinical records suggests that clinicians are more engaged in general health care issues of the individual. There has been noticeable improvement with following up by the clinician on the initial assessment of acute medical conditions. The Monitoring Team noted areas that continue to need improvement, such as the need for clinicians to follow up on acute medical conditions to full resolution, and ensure that all clinical efforts are well documented. All clinical conditions must have a comprehensive medical plan in place to address each condition identified. Of paramount concern is the Facility's less than optimal approach to neuromotor and musculoskeletal conditions, such as cerebral palsy, spasticity, contractures, degenerative spine disease, and arthritis. It is also important for the clinicians to understand the etiology of medical conditions diagnosed. For these reasons, the Monitoring Team determined that the Facility remains not in compliance with Provision L1. Provision L2. The Facility, and DADS Central Office, continued to improve their process of assessing clinician competency. The development, and implementation of specific audit tools, for common and serious conditions, was a positive finding by the Monitoring Team; however, continued improvement and development of these assessments is required. Scores of external audits were noted to be below acceptable limits; however, the Monitoring Team questioned the validity of the audit process, and found no mechanism that ensured that the audit process assessed the actual clinician being audited. In some cases, the auditors could assess the clinical competency of a previous clinician, or a clinician who was cross-covering, which would either adversely or positively affect the outcome results of the audit. For these reasons the Monitoring Team determined that the Facility is not in compliance with Provision L2. Compliance will require further development of the audit tool, and develop a mechanism to improve on specificity of the audit process, that will ensure that, for review of performance by specific clinicians, only the clinician being reviewed is the clinician being assessed. Provision L.3. The Monitoring Team was pleased with the initial steps to develop a meaningful medical QA process that included identifying initial core indicators, and for developing a database solution that will be used to analyze data elements. At the time of this review, because the medical QA process was not completed and implemented, the Monitoring Team determined that the Facility is not in compliance with the Provision L3. Compliance will require that a meaningful medical QA process be fully developed and implemented, and that it includes assessing clinical indicators for all common and serious medical conditions, syndromal conditions, and preventive health care issues. The Monitoring Team would like to compliment the Facility for its initial development of a solution to manage clinical data elements. Throughout its review, data was efficiently and accurately provided because of improvements made by the Facility's information technology department. Efficient, and efficacious management of clinical data elements is an essential component that is absolutely necessary for compliance with Provisions L1 through L3. Provision L.4. Because the Facility does not have effective policies and procedures that help ensure that standard of care practice is followed, and because the Facility's policy for medical services is not adhered to

	by the clinical staff, the Monitoring Team determined that the Facility is not in compliance with Provision L.4. Compliance will require effective policies on medical services to be developed and fully implemented. The Monitoring Team strongly recommends review and revision of the clinical pathways.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Provision L.1 is a broad provision that reviews and assesses the ability of the Facility to provide general medical care to individuals it supports at the Facility. During each review period, the Monitoring Team determines specific issues and individuals to review based on samples derived following observational assessments of individuals, at their home or day training program, and by randomly generated lists of individuals for predetermined topics. During the review, the Monitoring Team focused on staffing and administration, routine health care, preventive health, and chronic care issues, including pneumonia, osteoporosis, Down Syndrome, and four individual case reviews. <u>Staffing And Administration</u> This section describes medical staffing at the Facility, clinician licensure, CPR certification, and continuing medical education. Staffing**:** The Facility maintained a total of five full-time physicians, four consulting primary care physicians, and one full-time advanced nurse practitioner (ANP). The medical director made the Monitoring Team aware that there was an effort to convert consulting physician positions to full-time employee positions. Based on staffing ratios, and pending conversion of contract positions to full-time positions, the Monitoring Team considers the Facility's staffing plan to be adequate. The practice agreement for the ANP was reviewed, and noted to be out of date. A practice agreement must be developed and signed annually. The practice agreement did not identify who the primary delegating physician was, or who the alternate delegating physicians were. The Monitoring Team was unable to determine how the delegating physician ensures that the ANP is qualified to perform the duties outlined in the practice agreement, as required by the Texas Boards of Medicine and Nursing. There was no documentation provided to indicate that the ANP was registered by the delegating physician, with the Texas Board of Medicine. For the safety of individuals served, the Monitoring Team expects that all clinicians practice within their scope of their ability, have been properly trained, and that all applicable practice acts are adhered to. The licenses of all practicing clinicians were reviewed, and noted to be current in 10, out of 10 (100%) of the practicing clinicians.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Cardiopulmonary Resuscitation Certification (CPR): Of the 10 practicing clinicians 9 (90%), had current CPR certificates for health care providers. Continuing Medical Education (CME): Of the practicing clinicians, 10 out of 10 (100%) demonstrated CME credits during the past 12 months. The type of CME varied and included women's health issues, treatment of spasticity, pain management, infectious disease issues, and many other topics. <u>Routine Care</u> This section assesses the Facility's ability to provide efficacious medical care for routine health care issues. Issues addressed include timeliness of medical assessments, quality of the clinicians' integrated progress notes, access to specialists, and hospitalizations. Timeliness of Annual Medical Assessments: For all annual reviews completed in February 2012, 15 individuals were randomly chosen by the Facility, for review for timeliness of their annual medical summaries. A copy of the most recent, and prior annual medical summary and physical examination evaluation for Individuals #105, #197, #276, #537, #759, #594, #275, #4, #191, #13, #177, #571, #606, #726, and #228 were reviewed. Of the 15 unique samples, eight out of 15 (53%) were completed within 365 days. Integrated Progress Notes (IPN): The most recent two IPNs for each practicing clinician were reviewed to ensure that they were documented in SOAP format, and that they were timed and dated. Of the 20 IPNs reviewed, 16 (80%) were in SOAP format, and 20 (100%) were timed and dated. Importantly 20, out of 20 (100%) provided comprehensive documentation that enabled an understanding of the clinical issue being addressed. Comprehensiveness of Annual Medical Assessments: A randomly generated list of 15 individuals was obtained and the most recent annual medical summary, including the active medical problem list, annual medical summary, and physical examination, and the quarterly medical assessment were requested form that list (#55, #373, #698, #183, #669, #167, #334, #196, #232, #240, #565, #308, #14, #191, and #306). Following review of the assessments, 15 (100%) appeared to be thorough; eight (53%) included information about social history, including tobacco use; 15 (100%) were noted to be timely, 10 (67%) included a comprehensive statement regarding community transition; and 0 (0%) of the samples provided included a copy of the quarterly medical assessment. Access to Medical Specialists:	

#	Provision	Assessment of Status	Compliance
		The Monitoring Team discussed the use of medical specialists with the medical director, and was informed that the Facility has access to all necessary medical consultants, and that urgent consultation with a specialist can be arranged when necessary. The Monitoring Team reviewed the active clinical records for Individuals #105, #197, #276, #537, #759, #594, #275, #4, #191, #13, #177, #571, #606, #726, and #228 and noted that medical specialists were arranged timely, upon request by the primary care physician in 15 out of 15 (100%) of the cases reviewed. The Monitoring Team did not attend or evaluate on-site specialty clinics during this review period. Hospitalizations: To assess continuity of care during and following hospitalizations, the Monitoring Team requested the clinical records of the past most recent hospitalizations (Individuals #351, #337, #114, #5, #198, #32, #750, #526, #292, and #19). Specific documents reviewed included copies of the hospital admission and discharge reports; hospital liaison notes; interdisciplinary team meeting notes; and the physician documentation demonstrating appropriate clinical follow-up (Doc-to-Doc Note). Of the 10 cases reviewed, 10 (100%) included hospital liaison notes; eight (80%) included copies of hospital admission and discharge reports; three (30%) included notes indicating that an integrated team meeting occurred following the hospitalization, and 0 (0%) included a copy of the Facility's Doc-To-Doc transfer records, or other supporting documentation by the physician following the hospitalization. <u>Preventive Health</u> Preventive health is an important aspect of general health care. To assess the Facility's ability to provide preventive health care to individuals who reside at the Facility, the Monitoring Team reviewed aspects of immunization, vision and hearting assessments, and cancer screening by means of mammography, PSA screening, and colonoscopy screening. Immunization: From a list of individuals residing at the Facility, a randomly generated sample of 20 individuals were assessed to ensure that influenza and varicella zoster immunization was provided. Twenty (100%) were provided their annual influenza vaccine, and 20 (100%) individuals were immunized for varicella zoster or demonstrated positive titers and did not require immunization. The Monitoring Team did not assess how the Facility documents childhood vaccines, but will do so at subsequent reviews Vision and Hearing Assessments:	

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		Of the 20 individuals that were randomly chosen from the Facility's roster, 17 (85%) were provided timely and appropriate vision assessments, and 16 (80%) had timely and appropriate hearing assessments. Breast Cancer Screening by Mammogram: From the Facility's roster, a randomly generated list of 20 females over the age of 40 was requested, along with copies of their most recent two mammogram screenings, or documentation why mammogram screening was not performed. Review of mammograms indicated that 17 (85%) mammograms were current. Prostate Cancer Screening by PSA: From the Facility's roster, a randomly generated list of 20 males over the age of 50 was requested, along with copies of their most recent PSA results. Of the 20 samples reviewed, 20 (100%) indicated that a PSA screening test was completed within the past 12 months. The Monitoring Team is aware that PSA screening may not be indicated for routine screening in some cases, and recommends requesting informed consent for the screening of prostate cancer by means of PSA. Colon Cancer Screening by Colonoscopy: From the Facility's roster, a randomly generated list of 20 individuals, over the age of 50, was assessed to ensure that colon cancer screening was performed. Of the 20 samples reviewed, 16 (80%) had undergone screening colonoscopy. There was no documentation to support the clinical rationale for not performing colonoscopy on the four individuals who colonoscopy was not assessed. <u>Chronic Conditions</u> The following section assesses the Facility's ability to manage common medical conditions. Specific clinical conditions assessed during this review period included osteoporosis, pneumonia, and Down Syndrome. Osteoporosis: A list of 14 Individuals (#461, #66, #205, #737, #139, #520, #710, #244, #3, #362, #787, #247, #289, #769) was randomly generated, by the Facility, from a list of all individuals diagnosed with osteoporosis. Of the 14 individuals reviewed, 11 (78%), indicated that appropriate bone density assessments were obtained; 14 (100%) were prescribed calcium and vitamin D; 13 (93%) were prescribed appropriate pharmacotherapy, or indicated the rationale for not prescribing pharmacotherapy for osteoporosis; 0 (0%) demonstrated that secondary causes of low bone density were evaluated; 9 (64%) of the individuals' annual medical assessment indicated a plan that included treatment and follow-up for osteoporosis; 7 (50%) indicated that the clinician documented osteoporosis as a risk factor for restraint; 0 (0%) demonstrated effective	

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		communication of the risks, and benefits of treating, versus not treating osteoporosis, and non-pharmacological considerations for the treatment of osteoporosis, in the ISP; and 0 (0%) of the ISPs demonstrated appropriate recommendations by physical therapy for the management of osteoporosis. Osteoporosis is a common and serious medical condition that can result in severe morbidity and mortality, and a comprehensive search for underlying and reversible causes of low bone density is compulsory before starting pharmacotherapy treatment for osteoporosis. As with all medical conditions, the team, through the interdisciplinary process, must ensure that all risks associated with treatment versus no treatment have been explored, and that all non-pharmacological treatments and supports are considered for the individual. These important issues were not incorporated into the treatment plan or ISP for osteoporosis. Down Syndrome: In developmental disabilities, preventive health care must include a comprehensive understanding of common and serious manifestation of syndromal conditions, such as Down syndrome and Prader-Willi, among others. To assess routine care for individuals with syndromal conditions, the Monitoring Team randomly assessed 10 Individuals (#560, #637, #272, #345, #503, #423, #18, #82, #402, #320) from a list of all individuals known to have Down Syndrome. Specific issues assessed included the regular monitoring for thyroid disease, erythropoietic conditions, cardiac anomalies, and musculoskeletal conditions, including arthritis, degenerative spine disease, and cervical subluxation. Also reviewed were the Annual Medical Assessments, Physical Therapy Assessment, and the Personal Support Plan for Down syndrome, to ensure that they appropriately commented on necessary follow-up, risks, and necessary supports and services. Of the 10 cases reviewed, 10 (100%) included appropriate assessments for thyroid disease (TSH), erythropoietic disorders (CBC), and cardiac conditions (EKG, and echocardiogram, when necessary); four (40%) included necessary cervical spine imaging studies, such as an x-ray or CT; 0 (0%) ensured appropriate delineation for necessary monitoring, risks, and supports and services in the ISP and PT assessments; and 0 (0%) of the annual medical assessments included an appropriate plan specific for Down Syndrome. The following are five samples to highlight the Monitoring Teams concern over the Facility's lack of assertive management of Down syndrome: • Individual #637 is known to have significant degenerative changes of the cervical spine, which is not uncommon for individuals with Down syndrome, and appropriate follow-up, assessments and consultations were not noted in the	

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		documents provided. Close monitoring and treatment, when necessary, is required to prevent serious medical complications. The individual had an abnormal red blood cell finding, macrocytosis, which should be assessed. There was no diagnosis of macrocytosis, nor follow-up of this condition noted in the records. Macrocytosis may be caused by underlying nutritional causes that may result in irreversible neurological and behavioral changes. The PT/OT notes and ISP do not adequately reflect the necessary supports and services required to support this individual's medical conditions, especially the underlying severe cardiac condition and degenerative spine disease • Individual #560 is known to have degenerative spine disease; however, assertive assessment and monitoring for this condition was not evident by review of the clinical records. PT progress notes indicated that the individual developed a "stiff leg" style of walking, and was refusing to walk; however, referral for evaluation of this condition was not evident. Progressive degenerative spine disease is common in individuals with Down syndrome and regular assessment of this condition is required, with appropriate referral to specialist in the event of a change in condition. • Individual #345 has very severe degenerative spine disease, and had been referred to orthopedics for evaluation that recommended to closely monitor the individual for worsening deterioration of functional abilities. The ISP did not comment on the severity, associated risks, nor necessary supports and services required for this condition. Importantly, PT did not comment on the need for frequent monitoring for potential neuromotor worsening. • Individual #423 had imaging studies that demonstrated osteoarthritis of the C-Spine, L-Spine, Hip and knee. C-Spine degenerative joint disease (arthritis) was not documented on the active problem list. These conditions were not assertively management by the Facility, and the ISP did not adequately represent the condition, nor delineate the necessary supports and services needed for degenerative joint disease. • Individual #320 was appropriately assessed and managed by the physician for cervical spine subluxation and degenerative disk disease of the spine. The ISP did not reflect the serious risks associated with these conditions, nor the special precautions that are required to prevent spinal cord injury. Pneumonia: A list of the most recent 10 individuals who were admitted to the hospital for pneumonia, along with the hospital admission, and discharge records, post hospital transfer note by the physician, and all associated physical-nutritional-management team minutes were requested.	

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		Of the 10 samples reviewed one (10%) was admitted with a co-diagnosis of sepsis and required artificial respiratory support, indicating that the individual had advanced stage of the illness at the time of admission. Only two (20%) of the samples included a post transfer Doc-to-Doc note, and only two (20%) of the samples reviewed include a post hospital discharge summary. Although seven (70%) cases were reviewed by the PNMT following their hospitalization, 0 (0%) were determined by the Monitoring Team to have undergone an assertive review with meaningful clinical recommendations. For examples, for Individual #170 the PNMT noted that the individual experienced two episodes of aspiration pneumonia within a one-month period, the only comment by PNMT was "recommend the level of assistance and follow-up in six weeks." Fractures: The Monitoring Team attempted to review all long-bone fractures that occurred during the current reporting period. A total one long-bone fracture was reported on the Facility's Client Injury (Individual #460). Review of clinical documentation indicated that the individual was treated by a consultant, that there was no assertive follow-up documented in the IPN by the attending physician, and the PNMT, as well as IDT did not assertively assess, or follow-up on the individual through resolution of the injury. <u>Do Not Resuscitate Orders (DNR)</u> To assess the appropriateness of DNR orders, the Monitoring Team requested a list of all individuals who had an active DNR order, along with the clinical rationale for the DNR, and the classification of DNR. The Facility had seven individuals listed as having a DNR orders. Two (28%) were enrolled in a Hospice program. A specific DNR classification was assigned to all seven (100%) of the cases. A qualifying condition was determined, and appeared appropriate in all seven (100%) of the cases reviewed. <u>Individual Case Reviews</u> The following examples review the Facility's ability to provide comprehensive care of specific clinical issues. Phenylketonuria (PKU): During the review period of September 2009, the Monitoring Team noted significant issues regarding the medical support for individuals with PKU. All individuals with the diagnosis of PKU were assessed during this review (Individuals #556, #205, #33, #517, #414 and #787). Documents reviewed included the most recent medical assessments, current medication list, past 12 months of labs, and any consultation report specific for PKU.	

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		Of the six individuals reviewed 0, out of 6 (0%), had either an updated annual medical assessment, or specific physician note documenting a comprehensive plan to address PKU; two (33%) demonstrated routine monitoring of PKU levels during the last six months; one (17%) was prescribed specific medications or supplements for PKU; two (33%) were prescribed a PKU diet; and one (17%) was referred to a PKU specialist. The Monitoring Team did not identify more assertive management of PKU during this review period, compared to the previous review period. Individual #118: The individual was observed by the Monitoring Team to be sitting in a recliner, demonstrated what appeared to be spasticity of the upper and lower extremities, and experienced many episodes of myoclonic type movements, which were accompanied by the individual's head and neck turning to the right, his eyes deviated slightly to the left, and small amounts of secretions extruding through pursed lips. Staff reported that such movements were not uncommon for the individual. The most recent annual medical summary, dated 4/2/12, documented Individual #118 was diagnosed by his primary care provider with myoclonus, quadriplegia with mild spasticity, and seizure disorder. The individual had last followed up with a movement specialist on 8/25/10, and was to have follow-up in six months. On 4/27/11, the movement specialist recommended discontinuing Primidone; however, the physician did not start this taper until 12/7/11. An EEG report, dated 1994, indicated that the individual had significant epileptiform activity that may correlate with the individuals myoclonic jerking. The ISP dated 4/25/11 suggested that Baclofen would be restarted, in hopes of improving the worsening abnormal movements. At the time of this review Baclofen was not reintroduced. Also, the ISP documented that the individual would "sweat profusely and have frothy secretions that smelled like formula" during times of "intense tremors". The most recent annual medical assessment dated 4/2/12 did not indicate an action plan for the individual's quadriplegia with spasticity, or for the individual's abnormal movements. The most recent ISP addendum dated 3/7/12, did not address the individual's abnormal movements. The Monitoring Team determined that medical management was not assertive enough in assessing, treating, and following up on the individual's abnormal movements, and quadriplegia. Given historic EEG reports, observations reported by staff, and the unique characteristic of the movements observed by the Monitoring Team, abnormal epileptiform activity should be considered as a potential etiology.	

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		Individual #571: Individual #571 was observed by the Monitoring Team to have significant spasticity of all four extremities, and neck. In addition, the individual has contractures of the toes. The most recent annual medical assessment, dated 2/1/12, included the diagnoses of spasticity and severe scoliosis but did not list contractures of the toes. There was no comprehensive plan documented by the physician specific to the individual's severe spasticity, contractures, or scoliosis. The PT/OT update, dated 1/3/12 documented a request for addition evaluation for spasticity, and on 2/21/12 and 3/16/12, the individual underwent Botox injections for spasticity. There were no assessments noted in the medical records indicating that the individual was provided routine assessments of spasticity, contractures, or for efficacy of pharmacological treatment, Baclofen and Tiazanidine. The nursing assessment did not include a plan for the nursing management of spasticity and contractures. The most recent risk assessment documents that the individual is a medium risk for fractures because she has not sustained a recent fall or fracture. The Monitoring Team determined that medical support of this individual is less then adequate, because assertive management for spasticity, contractures, and scoliosis was not evident upon review. It is a positive finding that the individual was referred for Botox treatment; however, routine assessment for worsening, treatment efficacy, and the development of addition comorbidities of quadriplegia was not evident. Individual #715: The Monitoring Team observed individual #715 at his living area. The individual was sitting, unassisted, in his wheel chair, with the prescribed "medical air" device at his side and not attached to the tracheostomy. Direct care staff and nursing staff reported that the individual would not leave the "medical air" device on. Once placed on the tracheostomy, the individual would start to cough, and make attempts to remove the device. The need for "medical air" had not been evaluated in at least the past two years. In addition, the oxygen was connected to a humidifier, which facilitates moist air entering the individual's respiratory system. It was observed by the Monitoring Team that whenever the "medical air" was in place, the individual would ultimately require more assertive tracheal suctioning for secretions. The Monitoring Team believe the clinical rationale for the need to provide more suctioning is because copious amounts of water from the humidified air is entering the individual's respiratory system, resulting in cough, discomfort, and build up of increased secretions that could result in frequent pneumonia, and decrease oxygenation. The Monitoring Team requested oxygen saturation levels to be reported without the use of "medical air," and all results were above 94%, without the aid of "medical air." Although the individual is seen by ENT specialist regularly for the management of the trachea, the individual had not been	

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		assessed by a pulmonologist to determine the efficacy, and risk benefits of long-term use of humidified oxygen, as "medical air." The individual was diagnosed with spastic diplegia and contractures. There were no assessments noted in the clinical records specific to monitoring for these conditions. The annual medical summary, dated August 2011, did not describe the extent of this condition, and the plan only recommended "monitor for worsening signs/symptoms" but did not indicate what to monitor. PT/OT, and nursing did not routinely monitor for worsening diplegia. Spasticity and contractures can worsen with the aging process, and must be routinely, and assertively assessed and treated when necessary. The underlying etiology of the spasticity and contractures was not diagnosed. The individual was diagnosed with kyphoscoliosis, which was not effectively described in the medical assessment, and there was no regular assessment to monitor for worsening scoliosis, myelopathy, pain or discomfort. The individual was diagnosed by colonoscopy as having internal hemorrhoids on September 2010. Internal hemorrhoids can exacerbate over time, cause pain and discomfort, and result in worsening constipation, and possibly obstruction, in extreme cases. The Medical assessment only recommended "repeat colonoscopy in 5-10 years," and there were no routine, documented assessments completed to monitoring for worsening of hemorrhoids, as recommended on the annual medical assessment. The Monitoring Team is concerned over the lack of efficacious management of the individual's internal hemorrhoids, spasticity, contractures, kyphoscoliosis, and continue use of humidified air as "medical air," especially when direct care, nursing, and respiratory therapy staff were unfamiliar with the rationale for its use and did not follow physician orders on how to use "medical air" as prescribed. Individual #392: Individual #392 is an immobile individual who developed a recurrent abscess over the left hip region, following hip surgery several years ago when a hip fracture was stabilized with hardware. In January of 2011, the individual underwent surgery to remove internal hardware from the hip; however, the procedure was unsuccessful and several screws and plates could not be removed. Subsequently, the individual has had recurrent abscess of this region. The etiology of the recurrent abscess could be because of poor position, an underlying infection of the bone, or a combination of these things. Despite sending the individual to a wound clinic for treatment, the Facility did not follow recommendations by the orthopedic surgeon, and the individual was not referred back to orthopedic surgery for further evaluation.	

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		The Monitoring Team determined that clinical management of this individual's recurrent wound was not assertively addressed by the medical staff. Concerns over possible osteomyelitis, and, or failure to protect the wound from pressure, should be considered. SUMMARY The Monitoring Team noted many positive findings, such as significant improvement of medical assessments by the clinicians, and improved IPNs that are more comprehensive and include an assessment and plan, in most cases. Assessments tend to be done timely, and are legible. Review of clinical records suggests that clinicians are more engaged in general health care issues of the individual. There has been noticeable improvement with following up by the clinician on the initial assessment of acute medical conditions. The Monitoring Team noted areas that continue to need improvement, such as the need for clinician to follow-up on acute medical conditions to full resolution, more assertive management of chronic conditions, and ensure that all clinical efforts are well documented. All clinical conditions must have a comprehensive medical plan in place to address each condition.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	The following deals with the Facility's review process of clinical staff at the Facility. The Monitoring Team assessed the Facility's Physician Audit Tools, External, and Internal audit results and process. The Facility is provided semiannual External Physician Audits, which are conducted by physicians from alternate Developmental Centers within the DADS system. In addition, the Facility also performs its own internal audit assessment. The intent of the audits is to evaluate the clinical competency, and practice standards of each practicing clinician. During this review period, the Facility had undergone one External Physician Audit, and one Internal Audit, which took place in February 2012. For this review period, the Monitoring Team assessed a newly developed performance assessment tool, which was developed by DADS Central Office, and reviewed the outcome data of the external audits. External Audits The external audits were completed in February 2012, and a total of 11 clinicians were assessed. Of the 11 clinicians assessed, two (18%) were rated compliant for areas considered essential, and two (18%) were rated compliant for areas considered non-essential. Action plans were developed for all clinicians. Internal Audits Review of audit tool: To better enhance the audit process, DADS Central Office developed internal audit forms to assess the management of specific conditions, including diabetes, seizure disorder, osteoporosis, constipation and urinary track infections. The Monitoring Team was	Noncompliance

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		unable to perform a comprehensive review of the audit forms for each condition; however, the Monitoring Team recognizes that as part of a quality assurance review process for clinicians, it is essential that outcomes be assessed, and that standard of care practice is adhered to. The following examples may provide some guidance: • When assessing performance activity for the management of diabetes, the review should determine whether assessing A1C values for acceptable limits was done, and evaluate whether the manifestations of diabetes, such as gastroporesis, peripheral neuropathy, retinopathy, foot ulcers, and renal insufficiency were assessed, and treated as necessary. In addition, ensuring that all appropriate aspects of diabetic management, including diet, exercise, and psychological issues that may be impacting the illness. • When assessing competency for the management of osteoporosis, the review should determine whether the physician always searches for the etiology of low bone density prior to starting medical treatment, and whether alternate means of assessing bone density, other then DEXA were employed in the diagnostic evaluation process; also, non-pharmacological treatment for osteoporosis, and osteopenia should be prescribed by the physician. • Constipation is a serious and potentially fatal condition, and must be assertively managed. Untreated constipation can lead to obstruction and perforation of the intestine, aspiration, renal failure, heart failure and serious behavior issues. The audit should require specific assessment for the physical exam, such as did the clinician perform an inspection, palpation, rectal exam and auscultation of the abdomen, was toileting schedules, physical activity, assessment of fluid intake and positioning assessed. Importantly, was the individual assessed by the clinician at least quarterly, and more frequently if recurrent episodes of bowel delay was identified, and was the use of specialists incorporated into the care plan, when clinically indicated. Following review of the new audit forms for specific conditions, the Monitoring Team compliments DADS Central Office, and the Facility for developing and implementing an enhanced and more robust means of assessing physicians' core competencies. The Monitoring Team suggests further review of each of the new assessments, and ensure that outcome data, and standard of care practice expectations are incorporated into the assessment process. <u>Findings of internal audit:</u> Comparison scores for clinicians' internal audit assessments were not provided for review, so the Monitoring Team did not assess the outcomes of the internal audits, which also took place in February 2012.	

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		Mortality Review The Facility's mortality review process was assessed in collaboration with Section M of this report. The Nurse Investigator continued to maintain comprehensive tracking systems for tracking compliance with the Clinical Death Review Committee and Administrative Death Review Committee Policies. The tracking systems had significantly improved the Facility's ability to comply with the requirements of the policies. The Facility's Clinical Death Review Committee and Administrative Death Review Committee Policies had not been updated since 2006. Since the last review, 10 deaths had occurred at the Facility. There were two recent deaths for which the death review was not due for completion at the time of the compliance visit. General findings included: • Of the 10 deaths, the average age was 52.2 years (ages varied from 46 to 60 years of age). • A review of the Facility's Clinical Death Review Committee and Administrative Death Review Committee Tracking Reports indicated that 10 of 10 (100%) death reviews complied with the Facility's Clinical Death Review Committee and Administrative Death Review Committee Policies. This was a significant improvement from past reviews. • Three of the 10 (30%) deaths had an autopsy completed. • Zero of 10 (0%) were reported as unusual deaths. • Only eight of the 10 Unusual Incident Reports (UIRs) related to the deaths were provided for review. For one UIR, only three of thirteen pages were copied for review. According to the UIRs, five of the deaths occurred at local hospitals, one death occurred in a Long Term Care Facility, and two deaths occurred at the Facility. Four of the eight decedents' had Do Not Resuscitate (DNR) orders signed. • The cause of individuals' deaths, as listed on the Death Certificates, are listed in the chart below: 1. Primary Cause of Death: Asphyxiation of Gastric Contents Secondary Cause of Death: Gastro Intestinal Dysmobility (Gastroparesis) 2. Primary Cause of Death: Pneumonia 3. Primary Cause of Death: Pneumonia Secondary Cause of Death: Sepsis 4. Primary Cause of Death: Pulmonary Congestion Secondary Cause of Death: Anasarca and Volume Overload Tertiary Cause of Death: Acute Renal Injury and Anuria 5. Primary Cause of Death: Anasarca Secondary Cause of Death: Hypotension	

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		Tertiary Cause of Death: Pulmonary Edema 6. Primary Cause of Death: Acute Myocardial Infarct Secondary Cause of Death: Hypertensive Cardiovascular Disease and Mitral Valve Disease 7. Primary Cause of Death: Possible Acute Myocardial Infarct Secondary of Cause of Death: Coronary Artery Disease 8. Primary Cause of Death: Acute Renal Failure 9. Primary Cause of Death: Metastatic Ovarian Cancer 10. Primary Cause of Death: Pancreatic Cancer Review of the Facility's Clinical Death Reviews, indicated that more assertive assessment for the root cause of death was needed. The Facility must perform a root cause analysis for every death, identify the immediate, contributing factors of death, and develop meaningful action plans to mitigate unexpected, and untimely deaths at the Facility. The Monitoring Team believes that asphyxiation of gastric content is unacceptable, and has concerns over two additional causes of death related to pneumonia and sepsis. The Nurse Investigator continued to maintain a tracking system for recommendations resulting from the Clinical and Administrative Death Reviews through to resolution for each death. The Monitoring Team requested copies of the Clinical and Administrative Death Review Committees' Recommendation Tracking Logs for each of the 10 deaths; however, only eight were made available for review. The purpose for requesting copies was to review the quality of the recommendations and to validate whether or not they were carried-out through to resolution. A review of the eight deaths reviews revealed that recommendations made by the Clinical and Administrative Death Review Committees were limited primarily to the medical staff with a few from the nursing staff. The purpose of conducting death reviews is to ensure thorough, systemic, and integrated death reviews are conducted. A review of the eight deaths' recommendations made by the Clinical and Administrative Death Review Committees indicated that all recommendations had been carried-out through to resolution. This was an improvement from past reviews. As was recommended at the last review, the Medical and Nursing Departments, as well as the 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, in addition to providing consistency among the reviewers. According to the State Office Nursing Coordinator the State was in the process of revising	

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		the Death Review Policy. When the Death Review Policy is revised it should include a thorough, systemic, and integrated process to review all aspects of an individual's care leading up to death and to make systemic recommendations for care. The Facility had not conducted a Mortality Review, and Analysis of longitudinal data related to deaths in order to track, and trend systemic issues, develop corrective action plans for system issues, or evaluate the efficacy of the corrective actions. Facility leadership, along with leadership from the DADS Central Office, must be actively involved with such efforts. <u>Summary</u> The Facility, and DADS Central Office, continued to improve their process of assessing clinician competency. The development, and implementation of specific audit tools for common and serious conditions was a positive finding by the Monitoring Team; however, continued improvement and development of these assessments is required. Results of external audits were noted to be below acceptable limits; however, the Monitoring Team questioned the validity of the audit process, and found no mechanism that ensured that the audit process assessed the actual clinician being audited. In some cases, the auditors could assess the clinical competency of a previous clinician, or a clinician who was cross covering, which would either adversely or positively affect the outcome results of the audit. For these reasons the Monitoring Team determined that the Facility is not in compliance with Provision L2. Compliance will require further development of the audit tool, and develop a mechanism to improve on specificity of the audit process, to ensure that only the clinician being reviewed, is the clinician being assessed.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	This section reviews the Facility's quality assurance process for medical services, and requires that the Facility has a meaningful process to collect and assess data elements specific for clinical conditions, and that it has a process to rectify deficiencies. The Monitoring Team met, and discussed with the medical director the Facility's efforts in developing, and implementing a QA process for medical services. <u>Medical Quality Assurance</u> The Monitoring Team was pleased to learn that the Facility had taken assertive action in developing a meaningful QA process for medical services. Since February 2012, the Facility, under the leadership of its medical director, had identified core indicators that included hospitalizations, mortalities, pneumonia, enteral feeding, injuries, diabetes, and decubitus ulcers. This process will enable data elements to be reported in table and graphic form. The Facility will continue to identify additional indicators, such as constipation, and neuromotor conditions, and also ensure that specific outcome date, such as A1C, and bone density values are included as part of the data collected.	Noncompliance

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		At the time of this review, the Facility was in the process of developing a mechanism that ensures appropriate review and reporting of the data in the form of a QA report, following a committee review. Lastly, the Facility reported it will ensure that corrective action is initiated and that all remedies are monitored for efficacy. There was no report of any such corrective actions having been implemented by the time of the compliance visit. In addition to the monitoring of core clinical indicators that is being developed, the Facility conducted an internal audit of clinicians, as reported in Provision L2. <u>Additional Initiatives and Improvement Projects</u> In general, the medical department has made significant strides towards compliance. Specific areas of improvements include: • Development, and partial implementation of quarterly medical assessments, as noted by review of active clinical records • Significant improvement in documentation practice, as noted by review of the IPNs • Prompt triage of acute clinical conditions, as noted by review of the IPNs • Improvements in comprehensiveness of medical assessments • More thorough review of mortalities, noted upon review of mortality review summaries • Significant improvement with the ability to manage data elements, as determined by reviewing data management while conducting this review <u>Summary</u> The Monitoring Team was pleased with the initial steps to develop a meaningful medical QA process that included identifying initial core indicators and developing a database solution that will be used to analyze data elements. At the time of this review, because the medical QA process was not completed and implemented, the Monitoring Team determined that the Facility is not in compliance with the provision L3. Compliance will require that a meaningful medical QA process be fully developed and implemented, and that it includes assessing clinical indicators for all common and serious medical conditions, syndromal conditions, and preventive health care issues. The Monitoring Team would like to compliment the Facility for its initial development of a solution to manage clinical data elements. Throughout its review, data was efficiently and accurately provided because of improvements made by the Facility's information technology department. Efficient, and efficacious management of clinical data elements is an essential component that is absolutely necessary for compliance of Provisions L1 through L3.	

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L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	This section requires review of the Facility's policies and procedure for medical services. During this review, the Monitoring Team focused its review on the DADS clinical pathways that were developed to guide clinicians when addressing common and serious medical conditions of individual with intellectual disabilities. The Monitoring Team reviewed the clinical pathways for seizure disorder, diabetes, and osteoporosis. The Monitoring Team was made aware that the intent of the clinical pathways was to provide clinicians with a simple, and meaningful approach to the unique needs of individuals with intellectual disabilities, so as to ensure that physicians were made aware of the subtle nuances of the manifestation of certain conditions, unique diagnostic and treatment approaches, and specific monitoring of common and serious medical conditions that occur in individuals with intellectual disabilities. For example: • It is important for the clinician to understand that when diagnosing pneumonia, the individual may not present as one would without a developmental disability, such as not manifesting a cough, exhibit an infiltrate on x-ray, expressing an elevated white blood cell count or fever • When diagnosing osteoporosis it is important to understand positioning and behavioral issues when interpreting bone density, and known what other technologies one should consider. A clinical pathway should also discuss the important of identifying potential secondary causes of low bone density, prior to initiating treatment, among other considerations. • When managing diabetes the clinician must lead a comprehensive interdisciplinary team that considers all aspects of the individuals life, including behavioral and occupational issues. The clinician must understand how to manage critical issues specific to the administration fast acting insulin, the use of insulin pumps in people with intellectual disabilities. The clinician must also be aware how behavioral issues that are treated psychiatrically could be manifestations of hyperglycemia or hypoglycemia, among other issues, including the clinical considerations of using neuroleptics and certain antiepileptic drugs, in individual with comorbid diabetes. Pathways were expected to provide important references that outlined current standard of care practice, such as the National Clearinghouse Guidelines. Clinical pathways were expected to be an efficient resource and enable a clinician to understand how the interdisciplinary team at the Facility should be involved in the management of each condition. The Pathways reviewed by the Monitoring Team did not address the unique clinical considerations for managing medical conditions in individuals with intellectual, and	Noncompliance

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		other disabilities. Pathways did not describe important system issues, such as how the IDT is to be involved in the support of the individual, or documentation and data management considerations. At the time of this review, the Facility had not implemented the Clinical Pathways at the Facility. <u>Policy on Medical Care</u> The Monitoring Team reviewed the draft policy on Medical Care, Policy Number 009.2, which did not have an effective date, and it included highlighted areas that were to be deleted. Based on review of this document, the Monitoring Team noted that the Facility was not following its own policy, when providing medical care to individuals served at the Facility. For example, an effective medical QA process was not implemented; clinicians did not follow specific documentation practices, and were not monitoring chronic health care conditions consistent with accepted medical practice and community standards, all of which were required to comply with the Facility policy on medical care <u>Summary</u> Because the Facility did not have effective policies, and procedures that help ensure that standard of care practice is followed at the facility, and because the Facility's policy for medical services is not adhered to by the clinical staff, the Monitoring Team determined that the Facility is not in compliance with Provision L.4. Compliance will require effective policies on medical services to be developed and fully implemented. The Monitoring Team strongly recommends review and revision of the clinical pathways.	

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

1. Enhance follow-up and routine management of chronic care conditions. (Provision L.1)
2. Ensure that individuals who have syndromal conditions are assessed regularly for known clinical manifestations of the syndrome. (Provision L.1)
3. Make sure that routine monitoring for prostate cancer occurs through the informed consent process. (Provision L.1)
4. When diagnosing and treating osteoporosis, or other conditions that cause low bone density, ensure that a search for the underlying etiology of the low bone density is completed prior to initiating treatment. (Provision L.1)
5. Follow all CDC guidelines with regards to routine immunizations, included the process for verifying childhood immunization, and documenting immunizations. (Provision L.1)
6. For all acute conditions, including pneumonia, and fractures, the physician must regularly follow-up on the condition through complete resolution of the condition, and document in SOAP format in the IPN. (Provision L.1)
7. Ensure that all known medical conditions are reflected in the Annual Physician Summary, and active progress notes. (Provision L.1)
8. Make sure that there is an efficacious and comprehensive medical plan for each known medical condition. (Provision L.1)
9. The Facility must enhance its ability to diagnose, assess, and treat neuromotor, and musculoskeletal conditions. (Provision L.1)
10. Enhance quality assessment audit tools for external audits and ensure they assess outcome measures, and standard of care practice. (Provision L.2)

11. Ensure that physician external audits assess the performance of only the clinician being reviewed, and not the activity of prior clinicians or cross covering clinicians. (Provision L.2)
12. The Facility must perform a root cause analysis for every death, identify the immediate, contributing factors of death, and develop meaningful action plans to mitigate unexpected, and untimely deaths at the Facility (Provision L.2)
13. The Facility must conduct a regular review of all mortalities, and perform a trends analysis, along with recommendations for system improvement. Leadership at the Facility, and the State Office should be involved in the review process (Provision L.2)
14. Ensure that the medical QA process includes clinical indicators for all of the common and serious medical conditions managed at the Facility, and that they include assessments for the clinical management of syndromal conditions, and preventive health issues. (Provision L.3)
15. Make sure that the medical QA process includes a formal method for review, and that action steps for remediation are assessed for clinical efficacy. (Provision L.3)
16. Ensure that there is a robust management system that can efficiently and efficaciously store, enable real time updating and data retrieval, and report on all necessary clinical indicators. (Provision L.1 through L.3)
17. Develop, and implement necessary policies, procedures, and guidelines that enable efficacious medical practice that addresses the unique needs of individuals with intellectual disabilities, and meets or exceeds acceptable standard of care practice. (Provision L.4)

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment for Section M, Date: 3/16/12 2. DSSLC Action Plan for Section M, Date: 3/8/12 3. DSSLC Provision Action Information for Section M, Updated: 3/9/12 4. DSSLC Section M Presentation Book, no date 5. DSSLC Report for Monitors, Date: 4/2/12 6. DADS Pharmacy Services, Policy Number: 011, Effective Date: 9/26/11 7. DADS, Mediation Variance, Policy Number: 053, Effective Date: 9/23/11 8. DSSLC Division of Nursing, Multi Drug Resistant Organisms (MDRO) Policy, Revised Date: 12/30/11 9. DSSLC Division of Nursing, Hand Hygiene Policy, Revised Date: 2/2012 10. DSSLC Division of Nursing, Surveillance Policy, Revised Draft Date: 8/13/11 11. DSSLC Division of Nursing, Management of Employees with Infectious Diseases Policy, Draft Date: 8/15/11 12. DSSLC Division of Nursing, Nursing Protocol: Proper Techniques for Urinary Catheter Maintenance, Revised Draft, Date: 10/26/11 13. DSSLC Division of Nursing, Nursing Protocol: Glucometer Quality Control (QC), Date: 9/20/11 14. DSSLC Medication Variance Review Committee, Policies and Procedures Manual, Committees and Councils, 23, Date: 8/9/11 15. DSSLC Medication Variance Tracking and Procedures, Pharmacy Policy Number: 27.1, Revised Date: 2/15/12 16. DSSLC Procedure for Inpatient Medication Dispensing, Pharmacy Policy Number: 39, Revised Date: 2/28/12 17. DSSLC Medication Errors by Type, 9/2011 through 2/2012 18. DSSLC Pharmacy and Therapeutic Committee, Polices and Procedure Manual Committees and Councils-05. Dated: 2/1/10 19. DSSLC Division of Nursing Subject/Policy Title: Reporting Employee Absence and Employee Illness Log, no date 20. DSSLC Infection Control Manual and Policies 21. Texas Health and Human Services (HHSC) Training Guidelines – Infection Control Prevention and Practices, Revised Date: 12/23/11 22. DSSLC Nursing Organizational Chart 23. DSSLC List of Nursing Education, Dates: 9/19/11 through 4/2/12 24. DSSLC Nursing Training Schedule for 2012 25. DSSLC Nursing Training Outlines for Courses Taught 26. DSSLC Nursing Education Tracking Reports for Nursing Standardized Procedures-Protocols-Guidelines 27. DSSLC Nursing Minimum Staffing Reports, Dates: 10/2011, 11/2011, and 12/2011 28. DSSLC Nursing 2012 Full Time Equivalents (FTEs), Date: 4/3/12 29. DSSLC RN Case Manager Roster, Date: 2/27/12 30. DSSLC Staffing Patterns, Date: 3/2012 31. DSSLC Nursing Overtime Hours, Dates: 9/2011, 10/2011, 11/2011, 12/2011, 1/2012, and 2/2012

	32. DSSLC Nursing Contract Hours, Dates: 9/2011, 10/2011, 11/2011, 12/2011, 1/2012, and 2/2012 33. DSSLC List of Meetings Requiring Nursing Participation 34. DSSLC Nursing Meeting Minutes for past six months 35. DSSLC Infection Control Teaching Curriculum 36. DSSLC Competency Training and Development (CTD) Course Delinquency/Due List for Infection Control Course, Printed: 3/1/12 37. DSSLC Antibiograms and Epidemiology Reports for the last six months 38. DSSLC Immunization Tracking Reports for Tuberculosis and Flu Vaccination 39. DSSLC Infection Control Committee Minutes and Attachments/Handouts, Date: 11/17/11 40. DSSLC Infection Control Program Summary Report, Dates: 9/2011 through 1/2012 41. DSSLC Infection Surveillance Report for Scabies, Date: 1/6/12 42. DSSLC Infection Control Feedback from Medical Providers, Date: 4/6/12 43. DSSLC Medication Administration Observation Blank Form 44. DSSLC Medication Administration Observation Reports, Dates: 9/2011 through 1/2012 45. DSSLC Medication Administration/Variance Committee Minutes and Attachments/Handouts, 11/28/11, 1/15/12, and 2/15/12 46. DSSLC Pharmacy and Therapeutics Committee Minutes, Dates: 9/21/11, 10/25/11, 11/22/11, and 1/31/12 47. DSSLC Drill Meeting Minutes, Dates: 9/2/11 and 12/30/11 48. DSSLC List of Emergency Response Committee's Core Membership 49. DSSLC Incident Management Review Team Meeting Notes/Log Relating to Emergency Response/Drill Outcomes, Dates: 11/1/11, 11/2/11, 11/28/11, 12/1/11, 12/21/11, 12/23/11, 1/30/12, 1/31/12, and 2/24/12 50. DSSLC Information Regarding Status of Completing Emergency Equipment and Automated External Defibrillator (AED) Checklist Monitoring 51. DSSLC List Identifying the Location of Emergency Equipment and AEDs throughout the Campus 52. DSSLC Mock Medical Emergency Drill Schedule, Dates: 1/2012 through 12/2011 53. DSSLC Copies of Completed Mock Medical Emergency Drills, Dates: 10/2011 through 1/2012 54. DSSLC Responding to Hazards and Emergencies Training Curriculum and Competency-based Testing Material, no date 55. DSSLC CTD Course Delinquency/Due List for Basic Cardiopulmonary Resuscitation (CPR) and CPR for Healthcare Providers, Printed: 4/4/12 56. DSSLC Diabetic Management Team Meeting Minutes, Dates: 2/14/12 and 3/28/12 57. DSSLC Diabetic Management Review, Date: 4/3/12 58. DSSLC Infirmary Admission, Printed: 2/28/12 59. DSSLC List of At Risk Individuals 60. DSSLC Nursing Discharge Summary Form, Date: 11/7/11 61. DSSLC Independent Support Plan (ISP) Conference Calendar for April 2012 62. DSSLC Infirmary – 24 Hour Shift Report, Date: 4/3/12 63. DSSLC Infirmary Census and Hospital Report, Date: 4/1/12 64. DSLC Tracking Decubitus Report – Unresolved, Date: 4/4/12 65. DSSLC Current Open Wounds Report, Date: 4/2/12

	66. DSSLC Decubitus Summary Report, Date: 1/13/12 67. DSSLC Emails of Interdisciplinary Collaboration – Skin Integrity, Dates: 9/20/11 through 3/28/12 68. DSSLC Physical and Nutritional Management Committee Meeting Minutes, Date: 3/29/12 69. DSSLC Quality Assurance/Quality Improvement (QA/QI) Council Section M: Monitoring Tool Data, Dates: 2/21/12 70. DSSLC Sample of Universal Monitoring Tool 71. DSSLC Documentation/Infection Control Corrective Action Plans, Dates: 12/2011, 1/2012, and 2/2012 72. DSSLC Sample records reviewed for Admission/Discharge/Annual/Quarterly Comprehensive Nursing Assessments for individuals who were identified by the Facility as being at risk for specific health indicators: Individuals #336, #392, #279, #170, #394, #464, #337, #551, #42, #351, #517, #353, #331, #272, #355, #119, #573, #466, and #332 73. DSSLC Sample records reviewed for three individuals identified by the Facility with active Urinary Tract Infections: Individuals #573, #466, and #332 74. DSSLC Sample records reviewed for 12 individuals identified by the Facility with having had or currently have Skin Integrity issues: Individuals #750, #298, #32, #466, #220, #119, #394, #532, #279, #147, #464, and #392 75. Sample records reviewed for three individuals identified by the Facility diagnosed with Diabetes: Individuals #402, #517, and #505 76. DSSLC Sample Hospital Liaison Nurses' Hospital Reports reviewed for four individuals identified by the Facility were currently hospitalized: Individuals: #337, #170, #639, and #351 77. DSSLC Sample records reviewed for recently completed Integrated Risk Ratings and Accompanying Risk Action Plans for Individuals #129, #183, #336, #331, #165, #392, #177, and #114 78. DSSLC Sample records of 15 individuals' for compliance with Acute Illness and Injury and Documentation Protocols for Individuals #336, #392, #279, #170, #394, #464, #337, #551, #42, #351, #517, #353, #331, #272, 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. Maria Pangilinan, RN, Infection Control Preventionist 6. Linda Barnett, RN, Nurse Educator 7. Gwen Weiss, RN, Nurse Educator 8. Sherrie Jones, RN, Nurse Manager, Houston Park 9. Dawn Jones, RN, Nurse Manager, Timberhill 10. Hilda Clemente, RN, Nurse Manager, Eastfield 11. James Strickland, RN, House Supervisor 12. Karen Denton, RN, Nurse Case Manager 13. Valerie Kipfer, RN, MSN, State Office Nursing Coordinator 14. Connie Horton, RN, FNP, State Office FNP Consultant 15. James W. Galbreith, M.D. 16. Allana Garrison, RN, Quality Assurance Nurse Supervisor/ Cardiopulmonary Resuscitation Instructor

	17. Hillot Rogers, III, Security Officer 18. Terri Rogers, RT, Directory of Respiratory Therapy **Meetings Attended/Observations:** 1. Review of Section M Presentation Book with CNE and NOO, 4/2/12 2. Pharmacy and Therapeutics Committee Meeting, 4/3/12 3. QAQI Council Meeting, 4/3/12 4. Infirmary Morning Meeting, 4/4/12 5. Medication Variance Committee Meeting, 4/4/12 6. Mock Medical Emergency Drill in the Innovative Contractors of Denton (ICD) Building, 4/5/12 7. ISP for Individual #464, 4/5/12 8. Medication Administration Observations, Houston Park, 13 B and 13 C, 4/5/12 9. Physical Nutritional Management Committee Meeting, 4/5/12
	Facility Self-Assessment: The Facility's Self-Assessment, up dated 3/16/12, provided comments/status for Sections M.1 through M.6 of the Settlement Agreement. The Facility indicated it was not in compliance with Provisions M.1, M.2, M.3, M.5, and M.6. The Facility indicated it was in substantial compliance with Provision M.4. This was inconsistent with the Monitoring Team's findings, as Provisions M.4 was not found in substantial compliance. The Nursing Education Department had a well-organized infrastructure and had provided and validated the required training. In order for Provision M.4 to be found in substantial compliance, the training provided on all Nursing Policies, Procedures, and Protocols must be demonstrated through actual practice sufficient to meet individuals' health care needs. At the time of the review, the Nursing Department had not yet demonstrated that all Nursing Policies, Procedures, and Protocols had translated into actual nursing practices sufficient to meet individuals' health care needs. For the Self-Assessment, the Facility described for each Provision item, methodology the Facility engaged in to conduct the self-assessment for each Provision, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The data used to determine assessment ratings consisted primarily of the scores derived from the percentage of compliance achieved through the results of various monitoring tools, tracking and trending of reports generated through various committees, and training activities. This was a significant improvement in the Facility's Self-Assessment process. The Facility should review the activities in light of findings of the Monitoring Team to ensure the information gathered provides a complete assessment of the requirements of this Settlement Agreement. An Action Plan that accompanied the Self-Assessment listed action steps for each Provision to guide the Facility through substantial compliance with each Provision. The action steps primarily related to content from previous reports or specific recommendations made by the Monitoring Team. The actions steps did not reflect a comprehensive strategic action plan to adequately guide the Facility through the process of achieving compliance across all Provisions. The Facility should go beyond the content found in previous reviews and the Monitoring Team's recommendations, and consider forward thinking when developing future action steps directed at achieving compliance with all the requirements set forth in each Provision.

	Simply relying on previous report findings and the Monitoring Team's previous recommendations will not significantly move the Facility forward in achieving full compliance with each Provision.
	Summary of Monitor's Assessment: The Nursing Department continued to demonstrate a high degree of enthusiasm and commitment to moving toward compliance with all provisions of the Settlement Agreement. There had been significant improvement in many areas, although no provision was yet in substantial compliance. Improvements are still needed in the quality of nursing assessments and care plans. 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. The most significant progress was found in the following areas: The Diabetic Educator Nurse had completed a study to evaluate the effectiveness of the Diabetic Education Services and intervention on improving individuals' diagnosed with diabetes glycemic control. The study found evidence of improved glycemic control. She had formed a Diabetic Support Group, comprised of interdisciplinary staff, individuals' diagnosed with diabetes and those who were at risk for developing diabetes, and family representatives to promote increases social activities, interactions, and healthy food choices. The Wound Care Nurse worked collaboratively with the Individual Support Teams had continued to reduce/prevent the incidences of skin integrity issues. At the time of the review only four individuals had skin breakdown that was being aggressively managed. This was commendable considering the Facility's census of 504, of which many individuals were identified to be medically complex and/or fragile. The Infection Control Preventionist had made significant improvements in the organizational structure and quality of the Infection Control Program. DSSLC's Nursing Department had essentially remained stable since the last compliance review. 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. Since the last review, 18 nursing protocols had been implemented and were used to improve the quality of nursing care, but there remained opportunities for continued improvement for all aspects of managing and documenting care according to the established protocols. The Nursing Care Monitoring Tools continued to be completed, data analyzed and trended. Few systemic Corrective Actions Plans had been developed and implemented. The Monitoring Tools continued to lack weighting by significance 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 demonstrably reliable data. The Facility's Emergency Response System continued to make 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 had procured all of the required emergency equipment. Observation of an impromptu Mock Medical Emergency Drill was successful with little prompting by the instructor. It was evident from observing the staffs' performance they had been performing regular drills to enhance their competency. The staff were very proud of their accomplishments. The revised Emergency Response Policy had not been fully implemented nor the required staff trained. It appeared that the revised Emergency Equipment Checklist had not been put into use. However, the emergency equipment was being checked using the old forms. Following the visit, the Monitoring Team was informed that there was an error on the Emergency Equipment Checklist. The header was dated for September 2011; however, the form provided to the Monitor has been updated and has been in use since March 9, 2012. Provision M.2: This provision was determined not to be in compliance. Although continued efforts 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. Thirty-six of the RNs who completed the Physical Assessment and Documentation Class had received their final check-off. The enhanced knowledge and skills derived from the Physical Assessment 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. The care plans continued to lack adequate individualization to meet individuals' specific problems. The 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, although the Facility found it in compliance. The Nursing Education Department had a well-organized infrastructure and had provided and validated the required training. This Provision cannot met compliance until all the Nursing Policies, Procedures, and Protocol are demonstrated through actual practice sufficient to meet the individuals' health care needs. The Nurse Educators continued to maintain an excellent Nursing Training 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 continued to use the Nurse Education Handbook for new nurse orientation. The Preceptor Program for mentoring new nurses had been fully implemented. The Nursing Department was beginning to evaluate the effectiveness in relation to retention. The Nurse Educators had trained 100% of the non-nursing staff responsible for providing direct care to individuals on the Clinical Indicators of Health Status Change Class at New Employee Orientation and were also providing training to incumbent staff. Provision M.5: This provision was determined not be in compliance. The RN Case Managers continued drafting the Integrated Risk Assessments to present at the IDT meetings. There was continuing need for the

	other relevant disciplines to complete their respective areas timely, so that the RN Case Managers could have adequate time to aggregate the data and develop draft Integrated Risk Assessments to present at the IDT meetings. This was still an evolving process, which continued to need improvement to accurately rating individuals risk levels and develop meaningful Risk Action Plans. Provision M.6: This provision was determined not to be in compliance. However, this provision had made significant progress toward compliance. The Medication Variance Policy was implemented and data was being gathered for each type of medication variance. The Medication Variance Committee was in the process of analyzing data and determining how to represent it, and make it useful to improve medication practices. The Facility continued to have lack of medication rooms where individuals can receive their medications in privacy and the nurses can be free from distractions. 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.	<u>Facility Self-Assessment for Section M.1:</u> The Facility's Self-Assessment process included the following activities: • Reviewed and analyzed vacancy and turnover reports to determine fill rates of nursing positions. • Staffing reports were reviewed to determine if staffing was falling below identified standard numbers to ensure adequate staffing. • Reviewed Quality Assurance/Quality Improvement data for the Acute Illness/Injury, Documentation, Skin integrity, and Urgent Care monitoring tools and analyzed progress and compliance. An average of 13 monitoring tools had been completed every month since January 2012. Prior to that the Facility averaged 26 monitoring tools per month. • Infection Prevention summaries were reviewed for appropriate interventions, treatments, and corrective actions. • Drill committee meeting minutes were reviewed for compliance with the Emergency Response Policy. The Facility's Self-Assessment reported the following: • The quarterly compliance average for the Annual Nursing Assessment monitoring tool was 97.1% in the third quarter, with a slight decrease to 96.9% noted for the fourth quarter. It remained above the threshold of 85%. • Annual ISP assessment data were reviewed. There were 28 ISP annual planning meetings held in the month of December, 2011, with 17% of the assessments being completed within the specified time frame. There were 44 ISP meetings held in the month of January, 2012, with assessments completed within the specified time frame for 52% of meetings. • Data reviewed reflect 100% attendance by RN Case Managers at annual ISP	Noncompliance

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		meetings. Based on the findings from its Self-Assessment, the Facility determined this Provision was not in substantial compliance because of the lack of completed assessments within specified time frames prior to the ISP and the need to continue to improve the nursing summary documentation on quarterly reviews. This Provision of the Settlement Agreement includes a number of requirements that address various areas of compliance. These requirements include: staffing, quality assurance efforts, assessment and documentation of individuals with acute changes in status, availability of pertinent medical records, infection control, and mock medical drills and emergency response system. Additional information regarding nursing assessments and health care plans is found below in Provision M.2 and M.3 report. Information regarding nursing's responsibilities for incidents of restraints is included above in Provisions C.5 and C.6 of the report. Information relating to death reviews is found above in Provision L.2. <u>Monitoring Team's Findings</u> The Facility's Section M Self-Assessment stated they were not in compliance with this Provision and the Monitoring Team concurs. Review of Section M Self-Assessment, Section M Presentation Book, staff interviews, and review of documents, provided evidence that the Nursing Department had continued to make steady progress toward achieving compliance in all of the various requirements contained in this Provision. Further, the review of this Provision found evidence that validated the Facility's Self-Assessment activities, reported data, and findings upon which they based their status of noncompliance. <u>Staffing</u> At the time of the compliance review, DSSLC had a census of 504 individuals. Since the last review, DSSLC had 131 positions allocated for Registered Nurses (RNs), and 87 positions for Licensed Vocational Nurses (LVNs), of which 109.50 RN positions were filled with 21.50 positions vacant and 80 LVN positions filled with seven positions vacant. According to the CNE, five RNs were currently in orientation. Despite the vacancies, primarily for direct care nurses, the Nursing Department had remained relatively stable. 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 the past six months indicated that the nursing ratios per shift were occasionally not met. Most of the shortages occurred on the 6-2 shifts and were covered by the Nurse Managers and/or RN Case Managers. Because of the nursing vacancies and/or in the case of nursing shortages	

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		the Nursing Department continued to use agency nurses for staffing. A review of the nursing staffing analyses/reports for the past six months indicated that the number of contract hours for agency nurses and Facility nursing overtime hours steadily decreased. There was documented evidence that the Nursing Department continued to actively recruit nursing personnel through the use of advertisements, visits and/or rotations from area RN and LVN schools of nursing, made efforts to enhance retention through a preceptor program for newly hired nurses, and conducted an ongoing evaluation to determine the need to reallocate nursing positions to better meet individuals' nursing care needs, as well as the requirements of the Settlement Agreement. Refer to Provision M.4 for retention efforts made through the use of a preceptor program. The Nursing Administration and Management Nurses continued to be stable, highly motivated and dedicated to providing high quality nursing services. The Nursing Department continued to have experienced and competent specialty nurses, e.g., Wound Care Nurse, Diabetic Educator Nurse, two Nurse Educators, two Hospital Liaison Nurses, and an Infection Control Preventionist. This was demonstrated through interview and 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. Refer to information reported below in this Provision related to specialty areas of nursing practice. In order to meet compliance with the staffing requirements of this Provision, positive practices identified above must be maintained, and the other improvements should be made. The Nursing Department should: • 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 review of the Monitoring Plan for Settlement Agreement for Nursing (SAN) that the Nursing Department was consistently refining and improving their 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 SAN revised 1/1/12 indicated the following changes from that last review: • Sets of 15 monitoring tools were assigned to 15 RN Case Managers per month. • A Quarterly schedule was developed specifying the monitoring tools to be audited each month. Over the quarter all monitoring tools were audited. • Each Lead Nurse was assigned one individual per month for completing their	

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		specifically assigned monitoring tools as a means of inter-rater reliability. • The Data Analyst randomly assigns individuals' records for monitoring. • Timelines were established for the monitoring process. • The Section Leaders meet monthly to review data generated by the Data Analyst who calculated the percentage of compliance for each item on the tools as well as the overall percentage of compliance for each tool. The data are analyzed for trends and localized issues. When indicated, plans to correct identified issues were drafted for the monthly follow-up meeting. • The threshold percentage for compliance was increased from 80% to 85%. A review of the QA/QI Council Report of quarterly (November, December, and January) data for Section M Monitoring Tools revealed the following: • The reports generated from the QA database continued to be comprehensive, well organized, and provided detailed information for each section's monitoring tools. Trend data derived from the database included the following information: o Time frame from which the data was collected. o Data was analyzed and trended by month, quarter and cumulative to date, e.g., rolling 12-month. o Name of the monitoring tool from which the data was analyzed and trended. o Total number of tools completed for each monitoring tool analyzed, including the number of tools completed by nursing staff as well as number completed by the QA staff. o The percentage of sample size based on the Facility's census at the time of the audits. • The report described data in narrative and graphic form for each monitoring tool as well as a combination of monitoring tools for the quarter: Section M was subdivided and the percentage averaged into four sections that contained certain monitoring tools. Example: M.1 included the results for Acute Illness and injury, Documentation; Skin Integrity; Infection Control; and Urgent/Emergency/Hospital Care. M.2 included Annual Nursing Assessments. M.3 included Annual Nursing Care Plans, Management of Chronic Respiratory Distress; Pain Management; Prevention; and Seizure Management. M.6 included Medication Administration and Documentation. The results for the present quarter subdivided into four sections as described above, revealed the following percentage of compliance: o M.1 – 88.3% o M.2 – 96% o M.3 – 86.3% o M.6 – 98.2% o The overall compliance average for these sections during the previous three months was approximately 92.4%	

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		The above data did not include a comparison of QA Nurse's inter-rater reliability data to nursing audit data. According to the 1/1/12 revised 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 Action Plan stated the inter-rater reliability process projected for completion 3/31/12 was still in process. The Facility had a formalized process for writing corrective action plans (CAPs). Data from the monitoring tools was set for an 85% compliance rating. A CAP was required for item(s) on the monitoring tools that fell below 85%. An additional CAP was required if the items that fell below 85% had not showed any improvement for two months. A CAP can be requested at any time at the discretion of the QA/QI Council. Based on the monitoring tool data, none of the tools' overall percentages fell below 85%; therefore, according to Facility criteria, no systemic CAPs were indicated. However, there was a CAP initiated for individual items on the Infection Control Monitoring Tool falling below 85% compliance for December, January, and February, 2012. The Facility Action Plan stated the CAP process projected for completion 3/31/12 was still in process. As identified at the last review, 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 85% compliance required a CAP. This issue was discussed with the State Office Nursing Coordinator who stated there was some consideration given to revising the monitor tools in keeping with the Settlement Agreement and Health Care Guidelines. In the event the Nursing Care Monitoring Tools are revised, the Monitoring Team requested that they provide all Monitoring Teams with a copy of the revised tools. Further, the need to revise the Health Care Guidelines was discussed, particularly as related to the Preventative Health and Immunization Sections, because these standards of practice have changed since they were developed. The State Office should consider revising the Health Care Guidelines, particularly as relates to the Preventative Health and Immunization Sections. The monitoring process and development of outcome data for Section M of the Settlement Agreement continued to show steady progress since the last compliance review. Even though, the process was still maturing it should soon provide comprehensive measurement of outcomes toward compliance with all Provisions.	

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		The Nursing Department stated there were no other monitoring/auditing processes currently in place with the exception of the Nursing Care Monitoring Tools. In addition to maintaining the positive practices identified in the report, 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 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. • 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. • 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> Fifteen individuals' active medical records were reviewed for compliance with Acute Illness and Injury and Documentation Protocols for Individuals #336, #392, #279, #170, #394, #464, #337, #551, #42, #351, #517, #353, #331, #272, and #119; this review identified the following trends: Areas that showed improvement: • There was consistent use of the SOAP format for documentation. • The legibility of the nurses' handwriting had progressively improved since the last review. • The nursing staff consistently notified the medical providers' promptly when there were significant acute changes in individuals' physical and/or mental health status. • Adherence to the recently implemented nursing protocols for: Antibiotic Therapy, Vomiting, Diarrhea, Seizure Activity, Respiratory Distress/Aspiration, Temperature Elevations, Head Injury, Notification of Providers (PCPs), Enteral Feeding, Tolerance/Complications, and Minimum Documentation Requirements were progressively improving. However, the Nursing Department needs to monitor these protocols to ensure the nursing staff adheres to the protocols. • Follow-up documentation of assessments more consistently stated what would be followed up, but did not consistently state the frequency of the follow-up activities. • Individuals' response to per necessary (PRN) medication was more consistently	

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		documented on the back of the Medication Administration Record (MAR) as well as in the Integrated Progress Notes. • Individuals' level of comfort or discomfort and mental status were more consistently included in the assessments completed related to the illnesses or injuries. • The Post Hospital and Emergency Room Visit Records were consistently completed. • Documentation in the Integrated Progress Notes was beginning to show more collaboration/integration with other disciplines. Areas that did not show significant improvement: • 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 was taken. Due to the variation in degrees of temperatures taken by different methods and in order to accurately interpret the measurements, the method the temperatures were taken must be considered. • Errors made in documentation were not corrected properly with a straight line drawn through the entry, dated, and initialed. • There was a lack of documentation in the Integrated Progress Notes when Health Management and Acute Care Plans were initiated and when 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 according to protocol for acute illness and injury, resolution notes were not consistently documented. • When individuals were sent to the emergency room and/or hospital, the Hospital/Emergency Room and Transfer to Other Long Team Care Facility Forms were not completed or put in the unified records, if used. There was no documentation that skin assessments were completed before transferring individuals to the emergency room/hospital, or if not completed a note indicating that because of the medical emergency they were not able to complete the assessment. Nurse to nurse contact with the emergency room or hospital nurse was not documented. Notifications to the Facility administration, IDT, and/or family/guardian were not documented. There was no documentation that the transfer information was sent to the emergency room and/or hospital with individuals. Although improvements were noted through interviews, record reviews, and observations, the Nursing Department needs to ensure that the positive practices are	

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		maintained and strengthened to meet compliance with this requirement. The Nursing Department should continue to monitor compliance with all Nursing Policies, Procedures, and Protocols relating to acute care changes in status, to ensure they are strictly followed. <u>Hospital Liaison Nurses' Activities</u> The Monitoring Team interviewed the Hospital Liaison Nurses, listened to their reports at the Morning Infirmary Meeting on 4/4/12 for individuals hospitalized, and reviewed Hospital Liaison Reports, Integrated Progress Notes, and other related medical records for Individuals #119, #337, #170, #639, and #351. This review demonstrated that the Hospital Liaison Nurses continued to perform the following activities: They made daily hospital rounds (Monday through Friday). They reviewed individuals' hospital records for: Do Not Resuscitate (DNR) status, availability of adapted equipment, whether or not Physical and Nutritional Plans were followed, if applicable; and they reviewed systems, new physician orders, results of lab and diagnostic tests, discharge planning for estimated date of discharge, and medical/health needs after discharge. They interviewed nurses and physicians providing care to individuals. After the visit to the hospital, the Hospital Liaison Reports and all medical information were 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 Interdisciplinary Team (IDT) members. The Hospital Liaison Nurses routinely attended morning rounds and reported on hospitalized individuals. They maintained ongoing communication with the RN Case Managers, Unit Directors, Qualified Developmental Disability Professionals (QDDPs), Wound care Nurse Occupational and/or Physical Therapist, and other IDT members as necessary. The IDT members were notified as soon as pending discharges were known in order to discuss any necessary training or equipment needed upon discharge. In addition, the Hospital Liaison Nurses attended and participated in Physical and Nutritional Management Team (PNMPT), IDT/ISP, Clinical Death Review Committee, and Critical Incident Team (CIT) meetings as needed for hospitalized individuals. By the IDTs' having the Hospital Liaison Nurses' information readily available regarding hospitalized individuals' status, they were able to readily identify significant changes in individuals' health status that would require revising their risk ratings and risk action plans. <u>Diabetic Educator Nurse Activities</u> Since the last review, the Diabetic Educator Nurse reported continued refinement and expansion of the Diabetic Management Services. In addition to the activities identified in the last review, the Diabetic Educator Nurse performed the following new activities: • Since September, 2011, began evaluating data from daily surveillance visits to individuals with diabetes and their assigned staff to assess progress, review pertinent health information, and provide informal training to reinforce prior instruction regarding all aspects of diabetic management. The purpose of evaluating	

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		this data was to establish guidelines for standards of care for this population. • Since September, 2011, the trending of hypoglycemic and hyperglycemic episodes was added to the summary section of the Monthly Diabetic Tracking Spreadsheet. With the use of the monthly summary the IDTs were able to quickly assess the effectiveness/progress (or lack of) resulting from any adjustments made to individuals' medical or dietary regiments. It was reported that the modification to the monthly summary reports were found useful by IDTs, as well as the consulting endocrinologists. • Since September, 2011, Diabetic Emergency Management training had become a component of orientation for all direct care and nursing staff, as evidence by training records in CTD. The Diabetic Educator Nurse made monthly training opportunities available to direct care and nursing staff to reinforce key information related to diabetic management. Since September there had been 25 such training opportunities provided. Whenever appropriate to the individuals' plan of care, an entry was documented in the IDT not to reflect the instruction and staff response. She also provided education and/or communication with individuals' families. • In September, 2011, the Diabetic Educator Nurse revised the Health Maintenance Plan (HMP) for Diabetes and developed a HMP for Metabolic Syndrome. She in-serviced the RN Case Managers on these HMPs. • In September, 2011, the Diabetic Educator Nurse became a part of the IDT by performing the following activities: o Attending the Infirmary Morning Meeting and followed-up with investigations and reports to the IDTs regarding identified diabetic related issues. o Monthly, and as needed, provided IDTs with Diabetic Trend data, as well as attended IDT meetings when indicated. o Prepared annual diabetic reviews for individuals' annual Independent Support Plan (ISP) meetings. When indicated attended the ISP for individuals who were rated at high and medium risk for diabetes. • In September, 2011, developed, implemented, and trained the nursing staff on a Nursing Protocol for Glucometer Quality Control, to ensure standardized procedures were followed by all nurses when performing weekly quality control checks on glucometers. • In January 2012, began trending the frequency of call to the on-call physicians regarding blood sugars outside of the established therapeutic range. It was anticipated that as individuals' glycemic control improves, the frequency of notification regarding hypoglycemic and/or hyperglycemic episodes will decrease. This process had started too recently to have longitudinal data to analyze and trend. The Monitoring Team will follow-up on the status of the trend data at the next review.	

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		• In February, 2012, formulated a multidisciplinary/integrated monthly Diabetic Management Team Meeting. The purpose centered on how the team might impact the incidence and progression of diabetes and health related conditions in DSSLC's population. Although the current emphasis of diabetic management centered on the end results, the team felt that more attention was needed in prevention and limiting the progression of diabetes and related health risks. The team also included the collaboration with the endocrinologist. • In April, 2012, began planning a Diabetic Support Workgroup to plan a social support programs for individuals who are at risk or who presently have a diagnosis of diabetes. The Diabetic Support Workgroup was comprised of interdisciplinary staff, individuals diagnosed with diabetes and those who were at risk for developing diabetes, and family representatives. In addition, the Diabetic Workgroup should also provide an opportunity for informal and formal teaching of skills so individuals can improve their health status. Since this was in the formative stage of planning, the Monitoring Team will follow-up on the workgroup's progress at the next review. • Continued Quality Assurance activities related to the efficacy of Diabetic Management through comprehensive record reviews and review of diabetic trend data. Completed summaries of the data collected were pending at the time of the review. A review of the Diabetic Management Review, 4/3/12, described the rationale for selecting hypoglycemia and hyperglycemia indicators to study and measure the success of diabetic management. The methodology used for the study included: Monthly, each individual was evaluated for the incidence and timing of low blood sugars (<70 mg/dL) and high blood sugars (>300 mg/dL) readings. Most of the individuals who were identified at the highest risk for hypoglycemia and/or hyperglycemia included routine administration of insulin. Therefore, all individuals who received insulin routinely were included in this initial study of hypoglycemia and/or hyperglycemia events. The monthly totals for the past twelve months were recorded and graphed. In order to demonstrate the effectiveness of the Facility's enhanced diabetic management, mean values related to the incidence of hypoglycemia/hyperglycemia were graphed and trended for the year ending March 31, 2012. The results of the study found significant improvement in the incidence of hypoglycemia and hyperglycemia in more than half of the individuals in the study. Seasonal trends had a negative impact on the individuals' overall improvement, as evidenced by in increased incidence of hyperglycemia in most individuals. Facility-wide, trends continued to demonstrate a slow, steady trend of improvement. Significant improvement was observed for four consecutive months prior to March, 2012. Significant improvement was noted in the incidence of hyperglycemia facility-wide. Seasonal trends at the	

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		holidays had a negative impact on the Facility's overall progress. Recommendations resulting from the study that the Diabetic Educator Nurse will follow-up on included: • Continue monthly trending of individuals whose medical management includes the administration of insulin. • Establish glycemic goals and target ranges for each individual and modify study criteria to reflect achievement of the target range. • Use the trend information as a tool to facilitate better glycemic control. Share the information with the individual and members of the IDT. • Anticipate seasonal variances as a challenge to diabetic management. Work to modify dietary choices during the holidays, while recognizing the individuals' preferences and desire to participate in unit activities. It was positive to find, and to include the above study in the report to demonstrate that the Facility had self-initiated a study to measure the effectiveness of interventions put in place to improve the health status of individuals diagnosed with diabetes, as well as to use it a as benchmark for the Monitoring team to use in evaluating the Facility's ability to manage and improve the health status of individuals diagnosed with diabetes. The only concern identified with the study was using the measurement of blood sugars of 300mg/dL as an indicator to study as opposed to blood sugars of 200 to 250 mg/dL. According to current medical literature consistent blood sugars of 200 to 250 mg/dL can lead to tissue/organ damage. For future diabetic trend studies, the Diabetic Educator Nurse should consider collaborating with the Facility medical staff and consulting endocrinologist to evaluate lowering the hyperglycemia indicator to 200 to 250 mg/dL's. A review of records and related documents for Individuals #402, #517, and #505 demonstrated and validated several of the activities described above in the Diabetic Educator Nurse's reports: • Individual #517's annual trend report showed a steady decrease in monthly hypoglycemia episode events. There was also a steady decline in hyperglycemia episodes, except for the month of March where there was a moderate increase. • Individual #402's annual trend report showed a slight increase in monthly hypoglycemia episode events. There was also a steady decline in hyperglycemia episodes, except for the months of October and January where there was a moderate increase. • Individual #505: In preparation for Individual 505's community placement, a comprehensive and detailed diabetic history, current diabetic management plan, and instructions for the agency staff was developed and provided to the IDT. <u>Wound Care Nurse Activities</u> As was found at the last review, the Wound Care Nurse continued to maintain the	

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		positive practices identified by consistently following, tracking, and reporting skin integrity issues and decubitus ulcers. Because of the low incidents of actual skin breakdown/decubitus the Skin Integrity Committee had been disbanded and skin integrity issues were now reviewed and discussed at the quarterly PNMC meetings. The Wound Care Nurse reported that the Facility had a total of 13 total pressure ulcers during the months of October, 2011 through January, 2012. Of these, six were repeated openings of once resolved ulcers. The remaining seven were newly originated ulcers, five (71%) of which originated in a hospital on Individual #394. Two of the thirteen (15%) were newly developed ulcers that originated at the Facility. One for (Individual #532) was caused by an ace bandage wrapped too firmly over cling gauze causing a pressure ulcer. The other ulcer (Individual #279) was caused by a positioning issue. At the time of the review all of the thirteen pressure ulcers were healed. There were four active pressure ulcers (Individuals #147, #464, #532, and #392) at the time of the review for which the Wound Care Nurse was providing care and assisting the nursing and direct care staff with instruction for care. There was documented evidence in the records and/or through emails that the Wound Care Nurse collaborated with other relevant members of the individuals' IDT to provide integrated care. The Wound Care Nurse continued to prepare the monthly Tracking Decubitus Report and provided tracking information to the IDTs. The monthly decubitus data for 2010, 2011, and 2012 (January, February, and March) were summarized and presented on a color-coded bar graph. While there was an abbreviated legend identifying the various colors on the bar graph, the legend did not clearly indicate to the reader what the codes represented nor was there a narrative summarizing the data. A line to represent the mean or trend was not included on the graph. However, since January, 2011, there appeared to be steady a decline in the incidents of decubitus. A review of the emails provided by the Wound Care Nurse included communication with relevant IDT members regarding leaking G/J Tubes and/or leaking from old stoma sites that had not been closed which caused skin irritation and/or infection at the stoma sites involving six Individuals: #750, #298, #32, #466, #220, and #551. Although there was two-way communication between the Wound Care Nurse and other relevant disciples demonstrating that assessments, interventions, treatments, and instructions for care were being carried out, the problems with leaking stomas and skin integrity problems appeared pervasive/systemic. On 2/21/12, in a general email to the medical director, the CNE, NOO, and RN Case Manager, expressed the concern that the gastrointestinal (GI) physicians the Facility was using seemed to think it was acceptable for the stomas to leak excessively which burns the skin. It was further expressed that even in the best circumstances the nurses could	

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		not keep up with managing the constant leaking. The medical director said they could use any Medicare/Medicaid provider willing to accept their individuals. He asked the Wound Care Nurse to check with administration regarding the use of other GI physicians and to address the issue of leaking stoma sites with the providers at the morning report. There were no further emails found relating to the outcome of this issue. The leaking issue was found addressed/discussed at the PNMC per Minutes of the 3/29/12 meeting, and again at the PNM meeting on 4/5/12, which the Monitoring Team attended. However, the discussions centered on external and internal stabilization of the G/J Tubes to prevent dislodgement of the tubes. There was no final decision made regarding stabilization of the tubes. The matter was tabled for further studied. There was a decision made to protect the stomas area if leaking occurred on a case-by-case basis. The Wound Care nurse should be involved with all cases of stoma leaking. Individual #392 had a chronic problem with healing and redeveloping decubitus of the left hip. Presently, the wound to the left hip had reopened and had a large cavity of undetermined origin. The Monitoring Team physician and nurse discussed the individual's clinical course of care with the Wound Care Nurse, Attending Physician, CNE, Nurse Case Manager Supervisor, Infection Control Preventionist, State Office Nursing Coordinator, and State Office Nurse Practitioner Consultant. Individual #392 had an appointments scheduled with the plastic surgeon in April, 2012, and with an orthopedic surgeon in May, 2012. Because of the repeated breakdown of the hip wound it is essential that the underlying cause be identified and appropriate treatment provided to heal the wound. Refer to Section L for more information. In addition to the information reviewed above, the Infection Annual Report for 2011 indicated that the highest incidence of infections (36%) were skin and soft tissues infection, of which the number one was due to cellulitis in stoma sites that could be attributed to leaking tube feedings causing excessive moisture around the sites. The problems with leaking stomas resulting in skin irritations/infections needs urgent attention. Despite the issues identified above regarding the leaking stoma site with skin irritation and/or infections, as was found at the last review, it was commendable that there were no more individuals found with decubitus/pressure ulcers than was identified considering the Facility had a census of 504. Many individuals were rated at high risk for multiple conditions and considered medically complex/fragile. This was no doubt attributable to the competent skills and commitment of the Wound Care Nurse and her efforts to ensure integrated care. <u>Infection Control Preventionist Activities</u> Since the last review, the Infection Control Preventionist had continued to maintain the	

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		positive practices identified in the last report and had made significant additional organizational and programmatic improvements to the Infection Control Program. Listed below is a summary that highlights the content and scope of infection prevention and control activities undertaken since the last review: • The Infection Control Preventionist oversees the Infection Control Program and was responsible for the daily management of infection prevention and control activities. The Infection Prevention Program was multidimensional and included components of surveillance, education, consultation, and continuous quality improvement. Based on her previous experience as an Infection Control Preventionist, she has the knowledge that is appropriate to: Assess infection control issues, identify risks, and make recommendation for corrective action to eliminate or prevent the risks She demonstrated a good understanding of the principles of infection control and prevention, and data analysis. Her core responsibilities and time allocations were as follows, but may fluctuate depending on the needs of the Facility and issues affecting clinical practice: o 40% Surveillance Monitoring o 20% Education/Prevention Activities o 20% Infection Prevention Control Committee/task force related issues o 15% Employee Health Issues o 5% Policy and Procedure Development/Review • Infection Control Policies and Procedures Review/Revision/Development – The Infection Control Preventionist had reviewed numerous Infection Control Policies and Procedures that had been revised or drafted and/or approved, implemented, and the relevant staff trained. They included: o Multidrug-Resistant Organism (MDRO Policy was revised (draft) on 8/15/11, and approved on 10/18/11. The revised policy included Centers for Disease Control and Prevention (CDC) recommendations related to the colonization of Methicillin-resistant Staphylococcus aureus (MRSA). o Hand Hygiene Policy was revised draft on 8/15/11 and approved in February 2012. o Surveillance Policy was revised draft on 8/15/11 and was awaiting approval. o Management of Employees with Infectious Diseases Policy was drafted on 8/15/11 and was awaiting approval. o Nursing Protocol: Proper Techniques for Urinary Catheter Maintenance revised draft on 10/26/11 and was awaiting approval. o Conjunctivitis algorithm was created on 8/20/11. o MRSA algorithm was created 8/20/11. • The Infection Control Preventionist chairs the quarterly Infection Prevention Control Committee whose role was to oversee the development and implementation of the	

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		Infection Control Program. The Committee takes an integrated approach that included representatives from different departments, e.g., Medical Director, Facility Director, Assistant Facility Director, Chief Executive Nurse, Nursing Operations Officer, Dental Director, Pharmacy Director, Quality Assurance Nurse, Wound Care Nurse, Qualified Developmental Disability Professional, Habilitation Director, Housekeeping Director, and others as necessary. A review of the Quarterly Infection Prevention Control Committee minutes validated the participation of the interdisciplinary staff as well as discussion and disposition of identified infection control issues. Only the Infection Control Committee meeting, 11/17/11, minutes were available for review. There should have been a quarterly Infection Control Committee Meeting in February, 2012; however, the minutes of the meeting were not made available for review. A review of Incidence of Infection Annual Report for 2011, showed that the Infection Control Preventionist continued to track, analyze and trend the incidents of infections by type, percentage, and rate. Rates were calculated using a standardized formula, e.g., the number of infections, by type, divided by census times the number of days times 1000 (for 1000 patient bed days.). The report also included a narrative analysis of the highest incidents of infection, a listing with homes with the highest incidence of infections, corrective action plans for each type of infection, and a follow-up plan. The results of this Annual Report are listed below from the highest to lowest percentage and rate percentage: Infection Type / Percentage / Rate Skin and Soft Tissue / 36% / 9.52 Urinary Tract Infection / 17% / 4.56 Respiratory Infections / 15% / 4.07 Conjunctivitis Infections / 14% / 3.59 Other Pneumonia Infections / 9% / 2.27 Aspiration Pneumonia Infections / 4% / 1.12 MRSA Infections / 3% / 0.78 Pseudomonas Infections / 1% / 0.26 Clostridium Difficile (C. Diff) / 1% / 0.24 Vancomycin-resistant Enterococcus (VRE) / 0% / 0.11 Analysis of each of the highest occurring infections is summarized below: o Skin and Soft Tissues Infections: The leading cause of skin and soft tissue infections was cellulitis in stoma sites which could be attributed to leaking feeding tubes causing excessive moisture around the sites. Other types of skin and/or soft tissue infection were cellulitis caused by wounds, recent	

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		injuries to the skin, or skin infections caused by impetigo, furuncles "boils" and carbuncles. There were 440 cases of skin and/or soft tissue infections in 2011, compared to 593 cases in 2010. This was consistent with the Wound Care Nurse's findings as described above. o Urinary Tract Infections: The leading cause of urinary tract infections were due to Escherichia Coli (E Coli). Most of the infections caused by E Coli were Facility-acquired at DSSLC. A few were acquired at the hospital while individuals were admitted and treated. The majority of the individuals with urinary tract infections were urinary incontinent, and two individuals had suprapubic catheters. Urine culture and sensitivity studies were obtained on the majority of the individuals diagnosed with urinary tract infections. Individuals who were diagnosed but not showing signs and symptoms of the infection (colonized) were not treated with antibiotics. o Respiratory Infections related to Aspiration Pneumonia: The majority of individuals (52) who were diagnosed with aspiration pneumonia were sent to the hospital for further evaluation and treatment. There were 43 (83%) cases that were Facility acquired and nine (17%) cases that were hospital acquired. Out of the 52 cases, nine individuals were diagnosed with two to four repeated cases. The Facility formed a new committee comprised of the Medical Director, Facility Director, Chief Executive Nurse, PNMP Director, Dentist, Qualified Developmental Disability Professional Director, and Infection Control Preventionist, who meet weekly to review and discuss all possible ways to prevent/control aspiration pneumonia. See Section O for more information regarding this committee's activities. o Conjunctivitis Infections: The leading cause of conjunctivitis (as identified through environmental surveillance inspections) was due to cross transmission through the contaminated hands of healthcare workers and lack of environmental cleaning, especially of highly touched areas, e.g., doorknobs, bedrails, tables, chairs, telephones, and computer keys. • The Facility contracted with an Infectious Disease Doctor who agreed to provide consultation services to individuals and education to clinical staff. On 11/30/11 he presented an in-service on the recently revised MDRO Policy and MDRO Colonization to the medical providers and nursing staff. • Antibiogram – The Infection Control Preventionist prepared monthly antibiogram reports that provided the data collected to medical providers to maintain appropriate usage of antimicrobial agents. The data were also reported at the Pharmacy and Therapeutic Committee meetings and reflected in the minutes. • There was documented evidence that the Infection Control Preventionist followed up on communicable disease outbreaks. An example that demonstrated assessment, intervention/action plan, and follow-up was found with an outbreak of scabies	

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		reported in two homes on 1/6/12. • Hand Washing Surveillance – Hand hygiene continued to be addressed at New Employee Orientation and annual retraining. Infection Control Training sessions include practical handwashing demonstrations by the staff using ultra-violet light to show areas on the hands that were not properly washed. Handwashing and Standard Precaution Surveillance were done on a daily basis. At least 35 employees were physically observed monthly in the different homes/units using a hand hygiene monitoring tool. All audit findings were shared at the quarterly Infection Prevention Control Committee meetings, as well as at other relevant interdisciplinary team meetings, e.g., Incident Management Report Team, Environmental Team, and Residential Services. As a result of the audits some employees were found to have long fingernails and some were wearing acrylic or artificial fingernails. These violations were emphasized to the employees and they were instructed to comply with the Hand Hygiene Policy regarding fingernail requirements for health and safety issues. These employees were also reported to their supervisors. Due to the issues identified with the length of the fingernails, the Hand Hygiene Policy was revised to include recommendations from the CDC regarding the length of healthcare worker's fingernails. A review of the Handwashing compliance report July through December, 2011 validated that 100% of the 35 monthly observations were completed with corrective action taken when deficiencies were found. • Environmental Surveillance of Homes/Units for Infection Control Issue: Routine unannounced surveillance activities were conducted in homes/units. The findings regarding infection control issues found, data collected, actions taken, and follow-up information recorded in Surveillance Reports and provided to the Building Coordinators, Unit Managers and other relevant interdisciplinary teams. A sample of the Surveillance Reports were reviewed that validated such reports were prepared, distributed, and actions taken as described in the reports. • Bloodborne Pathogen Exposure Determination: The Infection Control Preventionist reviewed the job risk category in the Infection Control Policy. Bloodborne pathogen exposure and steps to follow in case an employee was exposed was included in the New Employee Orientation. Hepatitis B information was given to new employees and Hepatitis B vaccines were offered to all employees. Employees who did not want the vaccines were given declination form to complete. All employees and individuals who received Hepatitis B vaccines were entered into the employee database. As of 3/8/12, 736 (52%) of the employees were reported to have received Hepatitis vaccines. At least 126 employees were found to have received the first and second doses of the vaccine but did not return for their third dose, even with being sent reminder letters.	

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		• Due to the persistent delinquency in employees receiving their annual tuberculosis screenings, the Infection Control Preventionist made a concerted effort to increase screenings. At the time of the review, 99.8% of the employees were current with annual tuberculosis screenings. • The Texas Health and Human Services (HHSC) Training Guidelines: The Infection Control Prevention and Practices, revised: 12/23/11, was used for New Employee Orientation, annual retraining, and to reinforce training when indicated. • According to CTD's Course Delinquency/Due List, 3/1/12, 16 employees were delinquent in Infection Control training. • The Infection Control Preventionist was a member of Texas Society of Infection Control and Prevention. She completed the basic training course on July 28 and 29, 2011. She was scheduled to take the certification examination for Infection Control in March, 2012. The status of certification was not available for review. An interview with the Infection Control Preventionist discussed the method she used to ensure that she received real-time reports of infections. She stated that she attended Infirmary Morning Meetings, reviewed Pharmacy Antibiotic Reports, 24 Hour Nursing Shift Logs, and lab reports for cultures and sensitivities. The Nursing Department did not have a formalized reporting process that directly sent daily notification of infections to the Infection Control Preventionist. The high incidence of urinary tract infection was discussed. She related that most of the individuals who had repeated incidences of urinary tract infections were either incontinent or required catheterization and most of the culture grew out E Coli. E Coli is an organism commonly found in feces and can often be attributed to cross contamination when perineal hygiene is poor. From a review of the infection control data on urinary tract infections, it was evident she had a good understanding of contributing factors and had provided much education to the staff on perineal hygiene. However, the possibility was discussed for actually observing direct care professionals providing perineal hygiene and observing the nurses' technique when performing catheterizations. This could further assist with determining compliance with the training that had been provided. Records were reviewed for three individuals diagnosed with active urinary tract infections and who were being treated with antibiotic therapy at the time of the review (Individuals #573, #466, and #332); this review found the following problematic trends. • Zero of three (0%) were individualized adequately to meet the individuals specific needs. The baseline data and goals were missing on one ACP, and were inadequate on the other two. The ACPs were generic with a few strikeouts of information and had very little additional information related specifically to the individuals with the exception of adding the name of the antibiotic prescribed. For one individual (#332) the antibiotic was changed due to resistance of the organism to the initially	

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		prescribed antibiotic but the change was not made on the ACP. The frequency of assessments, what was to be assessed, by whom, and where to document was not included or was not specified. The only exception found regarding an effort to individualize an ACP, was a review and revision by the Infection Control Preventionist for an individual whose urinary tract infection was caused by MRSA. The revision included instruction to follow standard precautions when providing care and managing waste products. There was an accompanying Integrated Progress Note indicating the Infection Control Preventionist had trained the staff on the revised ACP. • Zero of three (0%) ACP contained instruction consistent with the Antibiotic Protocol. • Zero of three (0%) records reviewed found documentation in the Integrated Progress Notes that indicated the requirements contained in the Antibiotic Protocol were consistently carried out, particularly as related to "specific assessment data related to the presenting diagnosis", urinary tract infection. There was rare assessment data found related to the urinary system, such as assessing for low back pain, tenderness over the bladder region, flank tenderness (costovertebral angle tenderness to rule out pyelonephritis), frequency of urination, amount of urinary output, amount of fluid intake, and inspection of the urine's color, clarity, and character. A full set of vital signs was not consistently completed; often only the temperature was taken. The method temperatures were taken was not consistently documented. The Nursing Department should consider a real-time system to notify the Infection Control Preventionist of all individuals diagnosed with infections so that she could can promptly follow-up to ensure that appropriate infection control interventions were put in place, including an individualize Acute Care Plan, as well as reviewing the quality of the assessments and documentation, and to provide consultation and training when deficiencies were identified. <u>Availability of Pertinent Medical Records</u> Records were made available onsite without difficulty or delay. However, it was discovered when looking for individuals' active Acute Care Plans, that they were kept the Red Care Plan Book in the Units/Homes for ready access. When active problems were resolved the Acute Care Plans were filed in the unified record. The Red Care Plan Books were not part of the unified records. If the nursing staff had not assisted with securing the Acute Care Plans from the Red Care Plan Book, it would have been assumed there was no Acute Care Plans for the individuals the Monitoring Team was attempting to review. Numerous emails were provided to demonstrate integrated communication with other disciplines. The emails contained pertinent clinical information that should have	

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		been included in the Integrated Progress Notes. While emails were a quick and easy way to communicate with other disciplines, the failure to include relevant clinical information in the Integrated Progress Notes had the potential to interfere with continuity of care. <u>Mock Medical Emergency Drills and Emergency Response Activities</u> Since the last compliance review, the Facility continued to maintain the positive practices identified. The Facility continued to make steady progress toward issues identified that needed further improvement. Improvements were verified through review of documents, interviews and observations which included the following: • The Facility had obtained and had in place all of the required emergency equipment, including the AEDs as required by revised Emergency Response, Policy Number: 044.2, dated: 9/7/2011. In addition to purchasing the emergency equipment, large black storage trunks with wheels were purchased to secure and make equipment readily accessible to staff during an emergency event. In addition to purchasing emergency equipment for the designated areas of the campus, also two additional sets of emergency equipment and portable storage trucks were purchased--one in case more than one emergency occurred at the same time and/or to have as a spare and one to use for training purposes. The emergency equipment trunks were secured with pull away locks, which were checked daily by the Security Officers. • The Facility had developed a list of all emergency equipment and AEDs that identified their location throughout the campus. The Facility was in the process of posting signs where emergency equipment and AEDs were located to ensure staff knew the location of the equipment. • The Safety and Security Services' back-up security vehicle continued to be fully equipped with emergency equipment and a back-up security team to respond to simultaneous emergencies. All Security Officers continued to respond to Mock Medical Emergency Drills and actual emergency scenes. They also escort the community Emergency Medical Services (EMS) to the scene. • The required monthly Mock Medical Emergency Drills were scheduled and noted if they were not completed. The Security Director tracked and filed the drill reports. The Facility reported that 99% to 100% of the monthly drills were successfully completed. • The Quarterly Drill Committee Meeting included reports for all types of required drills. A review of the Drill Committee Meeting minutes, December 30, 2011, included a report on the completed drills for the quarter identifying the location of drills that were missed and follow-up action to be taken. The minutes stated that the revised Emergency Response Policy was discussed and approved by the committee and will be submitted for review in January, 2012. The next Quarterly Drill Committee Meeting was scheduled for March 20, 2012. If this committee meeting occurred, the minutes were not made available for review.	

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		• A review of the Incident Management Review Team Meeting minutes for the past six months included reports of the completed Mock Medical Emergency Drills along with any deficiencies found and the accompanying corrective actions taken. • 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 four staff were delinquent in CPR Basic training. This was an improvement since the last review where eight staff were found delinquent in CPR Basic Training. • An impromptu Mock Medical Emergency Drill in ICD was observed by the Monitoring Team and the State Office Nursing Coordinator at 9:23 a.m. on 4/5/12. The Innovative Contractors' of Denton (ICD) Building staff immediately responded to the scene and began to initiate appropriate drill procedures. It was readily apparent they had been participating in the drills and knew the location of the emergency equipment and their role and responsibilities. Other ICD staff made the phone calls to the nursing staff and simulated calling 911; other staff went to the entrance of Facility to simulate flagging the emergency services to the scene. The nursing staff were immediately notified and arrived at the scene with the emergency bag within three to four minutes. The drill was completed successfully with only minor prompting by the QA Nursing Supervisor/CPR Instructor. It was impressive to find that the nurses, from each of the Units whose individuals were participating in the workshop, responded to the drill. After the drill a debriefing was completed by the Monitoring Team to critique the drill performance with the CNE, NOO, QA Nursing Supervisor/CPR Instructor, Unit Nurse Managers, House Supervising Nurse, Director for Respiratory Care and Security Officer. The nursing staff were able to operate the emergency equipment successfully and all of the equipment was in good working order. The large black trunk was checked and was found to contain all of the required equipment. The staff were given the opportunity to self-evaluate improvements made to the Facility's Emergency response System compared to two years ago. They stated the last two years had brought about many changes and revisions to the Emergency Response System; as a result they had greatly improved their ability to respond to medical emergencies. They explained that two years ago: o Nurses carried limited equipment and had to wait for Security to bring emergency equipment. o Many of the staff were confused as to exactly what their roles were in relation emergencies. o Due to the lack of adequate integration and coordination of disciplines, emergency response time was not always optimal. o As a result of significant improvements that had been made in conducting	

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		Mock Medical Emergency Drills, the additional emergency equipment contained in portable trunks, and made available across campus there had been: ▪ Better integration and coordination of disciplines to ensure effective and appropriate response to emergencies. ▪ Emergency response time had greatly improved. ▪ Nurses were better prepared for managing emergencies. ▪ Better and faster access to emergency equipment allowed for improved care to individuals. ▪ Improved confidence of caregivers to be able to provide emergency assistance to individuals. ▪ The ability to be prepared for multiple emergencies across campus simultaneously. The staff were very proud of the accomplishments they had made over the past two years. A review of the completed Mock Medical Emergency Drill sheet for October through December, 2011, revealed the following areas that need further improvements: • A review of the 231 scheduled, found 222 (96%) were completed. It was of concern that of the 222 completed drills, only 62 (27%) were identified as "full" drills, with 160 (97%) typically only including one to three non-nursing staff. Only the "full" drills were conducted by the QA Nursing Supervisor/CPR Instructor. By not completing a "full" drill that included all relevant staff, including nurses, in the area of the drill, the intent of conducting routine drills was circumvented and failed to meet compliance with the Emergency Response Policy, 044. There was no explanation provided to understand the reasoning for not consistently completing a "full" drill as defined in the policy. The Facility should ensure that full Mock Medical Emergency Drills are completed. • In zero of 222 (0%) was there a physicians' or nurse practitioners' signature on the completed Mock Medical Emergency Drill sheets, indicating that they participated. • In zero of 222 (0%) was there an indication that different scenarios (as required by policy) were used in conducting the drills. • The Facility reported in their Action Plan that the following action steps were not completed by the projected completion dates but were in process. The action steps included: o The Emergency Response Policy, 044, had not been fully implemented. However, the required emergency equipment and AEDs had been procured according to the requirements of the policy. o Training of all required staff on the revised policy. o The use of the revised Mock Medical Emergency Drill Sheets, Emergency	

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		Oxygen Tank and Suction Machine(s) Checklist and the AED and Emergency Bag Check-off sheets. o The addition of the initial response time of staff onto the Mock Medical Emergency Drill Sheet. o The requirement for the Campus Coordinators to use the Emergency Equipment Walkthrough Checklists to identify problems/trends resulting from incomplete check of emergency equipment and development of CAPs when appropriate. o Posting of signs identifying the location of emergency equipment and AEDs throughout the campus. Although there had been continued improvements made, the Facility should maintain the positive practices identified in the report and make improvements on the following practices: The Facility should ensure that: • Full Mock Medical Emergency Drills are completed. • Different scenarios are used for conducting Mock Medical Emergency Drills. • Physicians and nurse practitioners attend the Mock Medical Emergency Drills. • Action steps identified in the Action Plan related to emergency response activities are completed.	
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.	<u>Facility Self-Assessment for Section M.2:</u> The Facility's Self-Assessment process included the following activities: • The monitoring tool for Annual and Quarterly Nursing assessments was reviewed monthly to identify trends in completion and timeliness of assessments • Published delinquency lists were reviewed for completion status of annual and quarterly comprehensive nursing assessments. • ISP attendance by nursing was reviewed for the period of 12/01/11 through 02/01/12. The Facility's Self-Assessment reported the following: • The quarterly compliance average for the Annual and Quarterly Nursing Assessment Monitoring Tool was 97.1% in the third quarter, with a slight decrease to 96.9% noted for the fourth quarter. It remained above the required threshold of 85%. • Annual ISP assessment data were reviewed. There were 28 ISP meetings held in the month of December, 2011, of which 17%, of the assessments completed within the specified time frame. There were 44 ISP meetings held in the month of January, 2012, with assessments completed within the specified time frame representing 52% the total of meetings. • Data reviewed reflect 100% attendance by RN case managers at annual ISP meetings.	Noncompliance

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		Based on the findings from its Self-Assessment, the Facility determined this Provision was not in substantial compliance because there was a lack of completed assessments within specified time frames prior to the ISP and the continued need to improve the nursing summary documentation on quarterly reviews. <u>Monitoring Team's Findings</u> The Facility's Section M Self-Assessment stated they were not in compliance with this Provision and the Monitoring Team concurs. Review of Section M Self-Assessment, Section M Presentation Book, staff interviews, and review of documents, indicated the Nursing Department had made minimal progress toward achieving compliance in this Provision. Further, the review of this Provision found evidence that validated the Facility's Self-Assessment activities, reported data, and findings upon which they based their status of noncompliance. A review of Admission/Discharge/Annual/Quarterly Comprehensive Nursing Assessments for 16 individuals who were identified by the Facility as being at risk for specific health indicators included Individuals #336, #392, #279, #170, #394, #464, #337, #551, #42, #351, #517, #353, #331, #272, #355, and #119. The review identified the following trends: • Nineteen of the 26 (73%) Annual and Quarterly Comprehensive Nursing Assessments reviewed were completed according to the individuals' ISP schedule. Although the assessments were not completed on time, they were completed after the due date. As was found at the last review, the annual and quarterly ISP schedules were often changed, and the RN Case Managers did not consistently change their annual and quarterly nursing assessment schedules, causing them not to be completed timely. According to the Facility's Action Plan, the Nursing Department had included an action step to address this issue, with a projected completion date of 3/31/12. However, the completion status indicated that the action step had not been started at the time of Monitoring Team's review. The Nursing Department should complete the action step for ensuring that the RN Case Managers change Annual and/or Quarterly Nursing Assessment schedules when they are revised by the QDDPs. • Twenty-eight of 28 (100%) Annual and Quarterly Nursing Assessments had BRADEN skin assessments completed. • Twenty-six of 28 (93%) indicated that the Annual and/or Quarterly Nursing Assessments were sent to the QDDP. • Twenty-seven of 28 (96%) contained the signatures of the RN Case Managers who completed the nursing assessments.	

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		A review of 17 of the most recent Admission, Annual, and Quarterly Comprehensive Nursing Assessments found the following trends: • Current active medical diagnoses were consistently included. • Sections I through IX of the assessments found the following trends: o The assessments in these sections showed some steady improvement in completing these section assessments with more substantive information in the summaries relative to the system assessed. The quality of the assessments and summaries varied from Unit to Unit and from RN Case Manager to RN Case Manager. The most notable improvements may be attributable to the RN Case Managers who received the State Physical Assessment and Documentation training. o The information contained in the section summaries was not consistently reflected in Section XI, Nursing Summaries. o The quarterly Comprehensive Nursing Assessments were not updated when there was a significant change in health status. o One of 17 (6%) contained documentation of polio immunization status. This immunization was left off the printed Comprehensive Nursing Assessment template. In addition to omission of polio immunization documentation, measles, mumps, and rubella (MMR), varicella, and hepatitis immunization documentation was frequently omitted. The State and Facility should add polio vaccination information to the Comprehensive Nursing Assessment template. • Section X, Nursing Problems, contained medical diagnoses as opposed to nursing problems/ diagnosis. The expectation was for nurses to write medical diagnoses/problems using nursing problem/diagnoses terminology. When the Nurse Case Manager Supervisor was asked why medical diagnoses were used, she explained that was because the Nursing Protocols for Developmental Disability Nurses templates were used for developing care plans and were listed by medical diagnoses. Just because the protocol templates were listed by medical diagnoses, nurses should not be prevented from using nursing terminology when identify health related problems. • Eight of 17 (43%) individuals' Comprehensive Annual/Quarterly Comprehensive Nursing Assessments contained nursing problems and an accompanying Health Maintenance Plan (HMP) for all identified high and medium risk ratings that required nursing interventions. Not all identified nursing problems/diagnoses had an accompanying HMP. Conversely, not all HMPs had accompanying nursing problem/diagnoses. The Nursing Department should ensure that nursing problem/diagnoses and accompanying HMPs are developed and implemented for all of individuals' high and medium risk ratings that require nursing interventions. Despite the training and monitoring the Nursing Department had put forth in order to	

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		improve the quality of the Section XI Nursing Summaries, since the last review, no significant difference was noted in the analyses and summaries of clinical data. The quality of the nursing summaries varied from Unit to Unit and RN Case Manager to RN Case Manager. A review of the Section XI Nursing Summaries found the following: • Since the last review in order to improve the analysis of clinical data, the Nursing Department had revised the format for Section XI, Nursing Summary into a variety of subsections which included: o Review of Health Status from previous quarter/annual, to include any surgeries o Health Risk Review o Nursing problems/Diagnoses identified and read for the diagnoses o Health Management Plans and Progress. o Community Integration • A review of the revised format used for documenting the quarterly/annual nursing summaries found that the segregation of the clinical data did not improve the quality of the summaries. The items contained in the summaries continued to contain raw clinical data without analyses to identify individuals' health status in relation to their problems. With the additional categories in the format, the clinical data were more fragmented, making it even more difficult to discern the individuals' health status in relation to each of their problems. • Only one of 17 (6%) adequately summarized each identified nursing problem and stated the individuals health status progress and the effectiveness of the HMP; this was Individual #279's second quarter Nursing Assessment, 1/24/12. Six (35%) other annual and/or quarterly Comprehensive Nursing Assessments showed some improvement in summarizing the raw clinical data but did not address each problem, describe individuals' health status progress or lack of progress, or report the effectiveness of the HMPs. The remaining 10 (67%) nursing summaries did not adequately describe individuals' identified nursing problems, health status progress or lack of progress; and the effectiveness of their HMPs. For example: o Individual #392's summary for identified nursing problems stated: ▪ *Respiratory same as PSP.* ▪ *Dental same as PSP.* ▪ *GI/G-tube same as PSP* ▪ *Constipation same as PSP* ▪ *Weight – remained within desired within range @ 90.4 #; she gained 2.4 # in the last quarter.* ▪ *Cardiac same as PSP* ▪ *Diabetes same as PSP.* ▪ *Skin Integrity same as PSP* • As was found at the last review, there was no consistent format used in writing the	

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		nursing summaries; although a standardized format, as described above, was supposed to be used. According the Facility's Action Plan's action step, nursing was to develop and implement a standardized format to use for completing the overall nursing summaries on the Comprehensive Nursing Assessment template. The action step was reported to be completed on 9/30/11. However, the nursing summaries review did not reflect the format was fully implemented. The Nursing Department should ensure that a standardized format is used for writing overall nursing summaries. The State Office had revised the Admission and Discharge to Community or Other Facilities Nursing Assessment format, including a section for special discharge instructions. A review of Individuals' #236, #683, and #458's community discharge nursing assessments found they were completed on the Comprehensive Nursing Assessment forms and were not adequate to provide comprehensive discharge plans that included special instructions for training the receiving agency staff. The revised Community or Other Facilities Nursing Assessment form and plan for special instructions showed promise and a good format for future discharge plans. The Nursing Department needs to implement and train the RN Case Managers on the revised Admission and Discharge to Community or Other Facilities Nursing Assessment form. The Monitoring Team will follow-up on the use of the revised Community or Other Facilities Nursing Assessment form at the next review. It was apparent that all levels of nursing management continued to lack a clear understanding as to how to analyze, summarize and present clinical data related to individuals' health problems to determine whether of or not there was progress related to their health problems; and how to evaluate the effectiveness of the nursing care plans. Although there had been improvements made, this Provision was not found in compliance and minimal progress had been made toward meeting 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 ensure: • The completion of the Action Plan's action step for ensuring that the RN Case Managers change Annual and/or Quarterly Nursing Assessment schedules when they are revised by the QDDPs. • That nursing problem/diagnoses and accompanying HMPs are developed and implemented for all of individuals' high and medium risk ratings that require nursing interventions. • That a standardized format is used for writing overall nursing summaries. • The implementation and training of the RN Case Managers on the revised Admission	

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		and Discharge to Community or Other Facilities Nursing Assessment form. • The Nurse Case Managers complete an addendum to the Quarterly Comprehensive Nursing Assessment when there are changes in individuals risk ratings or other significant changes in health status, and revise and/or develop and implement HMPs for changes in status. The State and Facility should consider: • Adding polio vaccination information to the Comprehensive Nursing Assessment template. • Providing the Nursing Department with technical assistance from an expert to provide competency-based training to assist the relevant nursing staff with critically analyzing clinical data into clear and concise summaries reflective of individuals' health status.	
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.	<u>Facility Self-Assessment for Section M.3:</u> The Facility engaged in the following activities in conducting its Self-Assessment for this Provision: • Monitoring tools for Annual Nursing Care Plans, Management of Chronic Respiratory Distress, Seizure Management, Pain Management, and Prevention were reviewed. • Reviewed the newly implemented tracking and trending reports related to the management of diabetes. • Reviewed reports from direct observations by clinical and administrative staff to provide validation of implementation and the effectiveness of interventions developed by the Incident Review Team (IRT). The Facility's Self-Assessment reported the following: Monitoring tools for Annual Care Plans, Management of Chronic Respiratory Distress, Seizure Management, Pain Management, and Prevention revealed the following trends: • The Annual Nursing Care Plan Monitoring Tool compliance decreased to 81% in the fourth quarter due to a low of 70.5% overall score in the month of December, 2011, but there was a significant increase to 87.4% noted in the month of January, 2012. • The Management of Chronic Respiratory Distress Monitoring Tool data reflected a decrease to 83.3% for the fourth quarter. Specific areas to be addressed related to the absence of Respiratory Therapists at ISP's and documentation of emergency respiratory assessments. • The Seizure Management Monitoring Tool data remained below the required threshold of 85% because of inconsistent documentation. • The Pain Management Monitoring Tool data remained above the required 85% threshold, with the third quarter data at 93.1% and the fourth quarter data at 94.4%.	Noncompliance

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		• The Prevention Monitoring Tool data remained above the 85% threshold, with the third quarter data at 94.2% and the fourth quarter data at 94.5%. • Tracking and trending reports reflect the current treatment regimen for individuals with diabetes. These reports were utilized to establish recommendations for changes in treatment. • Reports were provided by the assigned administrative staff to the IRTs and/or Mealtime Standards Committee who reviewed the newly implemented tracking and trending reports related to the management of diabetes. • Reviewed reports from direct observations by clinical and administrative staff to provide validation of implementation and the effectiveness of interventions developed by IRTs. Based on the findings from its Self-Assessment, the Facility determined this Provision was not in substantial compliance, although progress has been shown, improvement was needed on the implementations and interventions to optimize outcomes for the individuals' health care needs related to high risk or at risk health conditions. <u>Monitoring Team's Findings</u> The Facility's Section M Self-Assessment stated they were not in compliance with this Provision and the Monitoring Team concurs. Review of Section M Self-Assessment, Section M Presentation Book, staff interviews, and review of documents, indicated the Nursing Department had made minimal progress toward achieving compliance in all of the various requirements contained in this Provision. Further, the review of this Provision found evidence that validated the Facility's Self-Assessment activities, reported data, and findings upon which they based their status of noncompliance. As found in past reviews, a review of 17 individuals' HMPs and ACPs showed they continued to be generic and were copied directly from the Nursing Care Protocols for Developmental Disability Nurses' template. The plans were not individualized to meet individuals' specific needs in relation to their identified risks and/or active medical problems that required nursing interventions. A review of HMPs and ACPs for Individuals #464, #551, #351, #119, #517, #279, #331, #392, #170, #353, #42, #337, #336, #272, and #355 revealed the following. HMPs: A total of 143 HMPs were reviewed that indicated: • One hundred-twelve of 143 (78%) had adequate baseline data stated for the identified health problems. • Seventy-nine of 143 (55%) had adequate goals stated to measure the desired outcome for the identified HMPs. • The HMPs continued to be developed from the Nursing Care Protocols for	

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		Developmental Disability Nurses' template. Thirty of 143 (21%) were marginally individualized with the names and a few interventions changed sufficient to meet the individuals' health care needs; the others were copied directly from the Nursing Care Protocols. As reported in past reviews, these generic plans were not individualized to meet individuals' specific health care needs. • Zero of 143 (0%) HMPs were developed in collaboration with other relevant disciplines, with the exception of occasionally referring to other disciplines, e.g., PNMPs and/or PBSPs. • Zero of 143 (0%) HMPs adequately included proactive/preventative measures to reduce and/or eliminate risk indicators/problems. • Zero of 143 (0%) specified the frequency the interventions were to be carried out, by whom, and where the interventions were to be documented. • Zero of the 143 (0%) contained documentation in the Nursing Integrated Notes that the HMP interventions were carried out as described. • Forty-three of 143 (30%) HMPs were reviewed/revised at the time of Annual and/or Quarterly Comprehensive Nursing Assessments or when health status changed. Although there was documentation that the plans were reviewed, it was rare to find that the plans were revised, even when individuals had changes in health status. • One hundred-six of 143 (74%) HMPs contained documentation on the plans that the direct support professionals were trained and had special instruction sheets developed for the Me Books. It was positive to find that the special instructions developed for the direct care professionals were more individualized to meet individuals' health care needs that they were responsible for carrying out. The special instructions were written at a level that could be easily understood by the direct care professionals. • Eight of 17 (47%) had nursing problems/diagnoses and accompanying HMPs developed and implemented for all individuals' high and medium risk ratings that required nursing intervention. • The remaining nine of 17 (53%) individuals did not have one or more HMPs developed and implemented for all high and medium risk ratings requiring nursing interventions, or else they were not in the unified record or made available for review. The HMPs were kept in the Red Care Plan Books in the Units/Homes for ready access. However, the original HMPs are supposed to be kept in the unified record. Having two places to keep the HMPs has the possibility that not all HMPs will be kept in both places, and/or when the functional HMPs (kept in the Red Care Plan Books) were revised the original HMPs in the unified records may not also be updated. The Nursing Department should ensure when the functional HMPs in the Red Care Plan Books are revised, the original HMPs in the unified records are also revised.	

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		Examples of individuals' high and medium risk ratings for which nursing problems/diagnoses and/or HMPs should have been developed and implemented included: • Individual #517: Cardiac Disease, Circulatory, Fluid Imbalance, and Constipation. • Individual #464: Choking, Aspiration, Cardiac Disease, Osteoporosis, Fractures, and Weight. • Individual #170 who had complex medical/health conditions had a generic Health Maintenance, Altered, to address high and/or medium risk rating for Constipation, Mobility (Falls/Fractures), and Skin Integrity. This plan was designed for routine care and was not adequate to meet individuals' high and/or medium risks or active medical problems needs. The plan addressed routine care and was too general and nonspecific to address complex medical needs. This plan should not be used for individuals with high and/or medium risks or active medical problems. Acute Care Plans: Copies of all Acute Care Plans for the 17 individuals reviewed were requested for offsite review. Twenty-two ACPs were provided for review. A review of the individuals' Nursing Integrated Progress Notes, Physicians' Orders, and Progress Notes indicated there were numerous changes in individuals' health status that should have required the development and implementation of ACPs. Therefore, it could not be determined if no other ACPs were developed or just not copied for review. According to the Nurse Case Manager Supervisor the active ACPs were kept in the Red Care Plan Books in the Units/Homes for ready access. When the ACPs were resolved they were filed in the unified records. As with the HMPs, having two places to keep the ACPs has the possibility that not all ACPs will be filed in the unified records when they are resolved. The Nursing Department should ensure when the active ACPs kept in the Units/Homes' Red Care Plan Books are resolved they are removed and filed in the unified records. A review of the available ACPs revealed the same problematic issues as were found in review of the HMPs. Those findings included: • Twelve of 22 (55%) had adequate baseline data stated for the identified health problems. • Eighteen of 22 (78%) had adequate goals stated to measure the desired outcome for the identified ACPs • The ACPs continued to be developed from the Nursing Care Protocols for Developmental Disability Nurses' template. Thirteen of 22 (59%) were marginally individualized with the names and a few interventions changed to meet the individuals' health care needs; the others were copied directly from the Nursing Care	

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		Protocols. As reported in past reviews, these generic plans were not individualized to meet individuals' specific health care needs. • Seventeen of 22 (77%) contained documentation on the plans that the direct support professionals were trained and had special instruction sheets developed for the Me Books. It was positive to find that the special instructions developed for the direct care professionals were more individualized to meet individuals' health care they were responsible for carrying out. The special instructions were written at a level that could be easily understood by the direct care professionals. • Five of 22 (23%) contained documentation that the acute problems were resolved. • Zero of 22 (0%) indicated they were developed in collaboration with other relevant disciplines. • Zero of 22 (0%) included adequate proactive/preventative measures to reduce and/or eliminate risk indicators/problems. • Zero of 22 (0%) specified the frequency the interventions were to be carried out, by whom, and where the interventions were to be documented. • Zero of the 22 (0%) clearly contained documentation in the Nursing Integrated Notes that the ACP interventions were carried out as described. • The interventions described in the ACPs were not consistent with the Nursing Department's policies, procedures, and protocols. In order for improvements to be made regarding HMPs and ACPs, as required in this provision of the Settlement Agreement, the Nursing Department should ensure the following: • HMPs address all high and/or medium risk indicators and active problems that require nursing interventions. • HMPs are individualized to meet individuals' specific health care needs in relation to their identified risks and/or active medical problems. • HMPs are reviewed and/or revised at the time of the quarterly/annual nursing assessment or when there was a change in health status. • ACPs and HMPs include proactive/preventative measures to reduce and/or eliminate risk indicators/problems. • ACPs and HMPs contain integrated interventions in collaboration with other relevant disciplines, as required in Sections G and F of the Settlement Agreement. • ACPs and HMPs include who would implement the nursing interventions, how often they would be implemented, where they were documented, and how often they would be reviewed and/or revised. • When the functional HMPs in the Red Care Plan Books are revised, the original HMPs in the unified records are also revised. • When the active ACPs kept in the Units/Homes' Red Care Plan Books are resolved they should be removed and filed in the unified records.	

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M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	Facility Self-Assessment for Section M.4: The Facility's Self-Assessment process included the following activities: • A review of the Nurse Educators' reports to ensure that nurses received training on existing and/ or newly developed policies, procedures and protocols. • A review of the Nurse Educators' database for tracking required nurses' training. • Coordination of the final check-off for the Physical Assessment Class presented by Nurse Practitioners. • A review of the New Employee Orientation list to coordinate required training for incoming nurses. • A review of the calendar of monthly competency classes offered by Nurse Educators to incumbent nurses to update required competency-based training. The Facility's Self-Assessment reported the following: • All core State policies, procedures, protocols and processes developed by State Office had been adopted and implemented. • The Nursing Educators' database reflected a compliance rate above the required 95% threshold for core competencies. • Twenty-nine RNs had completed the final check-off for the Physical Assessment Class, presented by Nurse Practitioners, in February 2012. • Nursing Education provided monthly New Employee Orientation training to incoming nurses. • Competency of the month classes were offered by the Nurse Educators to incumbent nurses to update the required competency-based training and to ensure that nurses completed the required training. Based on the findings from its Self-Assessment, the Facility determined this Provision was in substantial compliance because the nursing department has established a 95% completion of core competencies. Monitoring Team's Findings The Facility's Section M Self-Assessment stated they were in substantial compliance with this Provision and the Monitoring Team did not concur, although review of Section M Self-Assessment, Section M Presentation Book, staff interviews, and review of documents, found there was evidence that the Nursing Department had continued to make steady progress toward achieving compliance with this Provision by establishing and maintaining a well-organized Nursing Education Program. Further, the review of this Provision found evidence that validated the Facility's Self-Assessment activities, regarding the reported training data. However, for compliance with this Provision to be achieved the Nursing Policies, Procedures, Processes, and Protocols in which the nurses	Noncompliance

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		were trained must be demonstrated through actual clinical practices, as described below. As was found in past reviews, the Nurse Educator had continued to maintain a comprehensive and updated Nurse Training Database to track all training provided to the nursing staff. A review of the database indicated that all of nursing required training had been completed by 90% to 100% of the nurses, with a projected date to complete training topics that had not been completed by 100%. The CNE reported there had not been any new core policies and procedures developed and implemented since the last review. However, in addition to the nine protocol cards reported at the last review, nine additional protocol cards had been developed for: Enteral Feeding: Tolerance/Complications, Hypothermia, Minimum Documentation, When to Contact the PCP, Seizure Activity, Status Epilepticus, PICA, and Abdominal Distention/Pain. This last set of protocol cards were implemented in 2/2012. To date the Nursing Training Database showed that 90% of the nurses received competency-based training on all protocols, with a projection to have the remaining 10% of the nurses trained by 4/15/12. The nursing protocol cards appeared to be clinically appropriate and in accordance with nursing standards of practice. The State Office Nursing Coordinator said all of the protocol cards had been cross-checked against the core Nursing Policies, Procedures and Processes to ensure consistency. Only the key components were placed on the protocol cards. The nursing protocol cards continued to be printed pocket size, laminated, and put onto a ring to carry. The Nursing protocols were to be carried by all nursing staff while on duty to provide a quick reference and to ensure adherence to the protocols. At the time of the review 100% of the nursing protocol cards had been distributed across campus. All protocols should be demonstrated through actual nursing practices. Additional nursing protocols need to be established and implemented in order to sufficiently address all aspects of individuals' health status needs. The required annual Nursing Competency Testing was provided 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 continued to be a much-improved approach to checking nurses' competency as compared to the previous Health Fairs where nurses checked each other off. In the past six months, 32 nurses identified as high performers had received the Preceptor training. The purpose of having trained preceptors was to have skilled and competent nurses mentor the new nurses, to reinforce the orientation training, assist them in the developing competent nursing skills, and to help foster retention. The	

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		Nursing Department was beginning to evaluate the effectiveness of the preceptor program. Thus far the effectiveness of the preceptor program showed: • From 1/2011 through 12/2011, 25 nurses were hired, with 13 of 25 (52%) retained. The CNE will continue to evaluate the effectiveness of the Preceptor Program using retention as well as other criteria. The Monitoring Team will follow up of the effectiveness of the Preceptor Program at the next review. The nursing orientation process continued for six weeks, which included the Preceptor Program to mentor the new nurses during the orientation period. In addition, a Nursing Orientation Survey was developed for the nurses to complete at least three months after orientation. This was initiated to further evaluate their orientation experience and to assist with retention. The improvements 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 Nurse Educators reported additional training that had been provided since the last review: • The State's mandated Clinical Indicators of Health Status Change Class provided to the incumbent direct care professionals and non-nursing staff was completed with 100% of the staff trained. 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. This class had become part of the required training in the New Employee Orientation. • MOSES/DISCUS refresher training was provided to RN Case Managers with 100% completing the training. • For the State Physical Assessment Class taught by the State Office Nurse Practitioners, 33 RNs were checked off in 9/2011, and 36 RNs had their final Check-off in 2/2012. • The State Documentation Class taught by the State Office Nurse Practitioners was completed by a total of 128 nurses. In order for this Provision to meet compliance, not only must the core Nursing Policies, Procedures, Processes, and Protocols be established, implemented, and the nursing staff trained, but also they must be demonstrated through actual clinical practice sufficient to address the health status of individuals served. As was found throughout the other Provisions, the Nursing Policies, Procedures, Processes, and Protocols have not yet been adequately put into clinical practices sufficient to meet individuals' health status needs. Therefore, this Provision was not found in compliance. The Nursing Department and the Nurse Educators should continue to reinforce and	

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		monitor the nursing practices contained in Nursing Policies, Procedures, Processes and Protocols, to ensure they are demonstrated through actual clinical practices sufficient to address the health status of individuals served.	
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.	<u>Facility Self-Assessment for Section M.5:</u> The Facility engaged in the following activities in conducting its Self-Assessment for this Provision: Self-assessment activities for Section I participated in by the Nursing Department related to discussion of At Risk Individuals at the PNMC Committee Meetings were also assessed for this provision. Many initiatives and processes had been implemented or were in development. Listed below are the activities engaged in to conduct the Self-Assessment for Section I: • Reviewed the At Risk Individual Policy to ensure that it included information required by the Settlement Agreement. • Reviewed the overall risk data by home, and then compared it to home population rosters to determine if all individuals had a risk assessment completed. • Reviewed specific high risk categories and compared them to other clinical data to determine if the numbers of those identified at high risk correlated with other data. • Reviewed monitoring requirements for Section I to determine current monthly compliance percentages. • Selected and reviewed an additional sample for Self-Assessment purposes. The Facility's Self-Assessment reported the following: • The Physical Nutritional Management Committee included the Chief Nurse Executive, the Nurse Operations Officer, the RN Case Manager Supervisor, the Infection Control Nurse, and the Skin Integrity Nurse. • The At Risk Individual Policy included a risk screening, assessment and management system. • All individuals currently had risk ratings completed by their interdisciplinary teams including the individuals most recently admitted to the center. • Lists of individuals rated at high and medium risk were pulled for Aspiration, Choking, Respiratory Compromise and Challenging Behavior. A review of these lists indicated apparent variation in their ratings of individuals. Only one individual that had a choking incident during the last five months was identified as high risk for choking. The lists for risk of aspiration appeared to be more accurate but under-rating was still suspected. A sample of those with incidents of aspiration during 2011 was reviewed and all but one or 94.2% were on the list. • Section I monitoring data revealed too few data tools were being collected for an accurate comparison. Current data indicated 0% success in January and a	Noncompliance

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		subsequent downward trend in success over the time period in this area. Data varied between 0% and 100%. • Due to the small number of tools used and the variation, an additional sample of risk documentation for those with changes in status was pulled. This data showed an overall success of 78.57%. A 100% of those pulled; however, had taken action to reduce risks. Based on the findings from its Self-Assessment, the Facility determined this Provision was not in substantial compliance because there was still a suspected underrating of individuals' health risks, insufficient collection of data, and lack of inter-rater reliability. <u>Monitoring Team's Findings</u> The Facility's Section M Self-Assessment stated they were not in compliance with this Provision and the Monitoring Team concurs. Although review of Section M Self-Assessment, Section M Presentation Book, staff interviews, and review of documents, found evidence that the Nursing Department had continued to receive additional training toward achieving compliance in this Provision, no significant improvement was found. Further, the review of this Provision found evidence that validated the Facility's Self-Assessment activities, reported data, and findings upon which they based their status of noncompliance. The RN Case Managers, in conjunction with the physicians, continued to be responsible for aggregating, reviewing risk factors, and drafting Integrated Risk Assessments to present to the IDT at the ISP meetings for the following categories: Aspiration, Respiratory Compromise, Cardiac Disease, Circulatory, Constipation/Bowel Obstruction, Diabetes, Gastrointestinal (GI) Problems, Osteoporosis, Seizures, Infections, Fractures, Fluid Imbalance, Hypothermia, and Urinary Tract Infections A review of eight recently completed Integrated Risk Ratings for Individuals #129, #183, #336, #331, #165, #392, #177, and #114 revealed the following trends: • The Integrated Risk Rating Form and Risk Guidelines had been rearranged so that risk categories on the forms provide a more logical approach to linking related risks together. • One of eight (13%) Integrated Risk Ratings adequately rated the individuals on all risk categories based on the supporting clinical data included in the rationale column. • Five of eight (63%) included BRADEN scores for skin integrity rating. • Individuals' Integrated Risk Ratings varied in the quality of substantive clinical data to support the various risk ratings, over time and with the different IDTs. Risk categories were not consistently rated accurately according to the Risk Guidelines	

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		and/or the individuals' heath status based on medical history, treatment regimens, and other supporting clinical data that was noted in the rationale, nor was clinical data included that should have been to make sound judgments related to the specific risk rating categories. It did not appear that all relevant clinical disciplines contributed substantive clinical data for their respective areas of expertise. Examples: o Individual #392 was rated at high risk for aspiration compromise and at medium risk for choking but rated at low risk for respiratory distress. The clinical data for respiratory compromise did not consider the clinical data for aspiration and choking when rating respiratory compromise; which included receiving nutrition enterally, frequent episodes of increased residuals requiring feeding delay due to slow gastric emptying and the diagnosis of gastroesophageal reflux (GERD), which was treated with medication, frequent episodes of emesis; recent history of low oxygen saturation (71% to 61%) that required oxygen, and diagnoses of bronchitis. Based on this clinical data consideration should have been given for at least medium risk rating for respiratory compromise. Skin integrity was rated high because of chronic problems with decubitus ulcer but the clinical data did not include the BRADEN score for risk of skin integrity. The individual was rated at low risk for weight but the clinical data indicated that for the past year she had consistently weighed below her desired weight range, except for the last two months of the year where she had gained weight to meet the low range of the desired weight range. Although, the weight had met the low range weight, her weight had not increased/stabilized long enough to be assured that she was no longer at risk for underweight. Consideration should have been given to at least rating weight at medium, if not at high risk. o Individual #129 was rated at high risk for aspiration compromise and respiratory compromise but rated at low risk for choking. The clinical data for aspiration and respiratory distress was not considered when giving a low risk for choking, which included continuous nutrition enterally, drooling, diagnoses of chronic respiratory disease with numerous hospitalizations for bronchitis and pneumonia. This data notwithstanding, according to the Risk Guidelines low risk is rated when individuals receive regular diet texture. The fact that Individual received continuous enteral nutrition should have placed her at least at medium risk for choking. In addition, Individual #129 was rated medium risk for skin integrity although she had a BRADEN score of 12 with a history of numerous episodes of skin integrity problems and had contractures that require Botox injections. Based on the Risk Guidelines, a BRADEN score of 12 or less indicated a risk rating of high for skin integrity.	

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		o Individual #331's risk categories contained inadequate clinical data to justify the rating. The clinical data consisted primarily of medical diagnoses, medications and a few lab and diagnostic test results. Individual #331 was rated at low risk for fractures because he had no fractures in the past three years; but was rated at medium risk for falls due to a history of frequent falls, altered mobility, and uses a rollator walker, was hearing impaired, and diagnosed with osteoporosis. He was rated at medium risk for osteoporosis. Therefore, consideration should have been given to at least a medium risk rating for fractures. o Individual #183 was rated at low risk for fractures but rated at medium for osteoporosis and falls. The clinical data for osteoporosis stated the recent DEXA-T Scores showed the spine at -0.2, hip at -2.2, and left femoral neck at -3.1, which correlates with an increase facture risk 15 fold. She is receiving medication for the treatment of the osteoporosis that was reported to be effective because there had been on fractures. However, this should not have removed the risk of fracture and consideration should have been given to rating fractures at high risk, as well as rating at high risk for osteoporosis; which was rated at medium risk. o Individual #114 was rated at high risk for aspiration and respiratory compromise but low for aspiration and choking. There was no clinical data entered in the rationale column to support the reason for the low rating for aspiration and choking. He was rated at high risk for cardiac but at medium risk for circulatory although the clinical data indicated that he was diagnosed with congestive heart failure on 12/31/11. He also had venous stasis and varicose veins and was diagnosed with deep vein thrombosis on 8/8/11. This should have indicated that he was at high risk for circulation. The risk categories that were rated at low risk did not contain any clinical data to support the low risk ratings, e.g., constipation, diabetes, seizures, falls, fractures, hypothermia, and dental. According to the At Risk Individual Policy, all risk ratings should contain clinical data to justify the ratings. A review of six of the Risk Action Plans accompanying the Integrated Risk Ratings for Individuals #129, #336, #331, #165, #392, #177, and #114 (#183 and #114 did not have accompanying Risk Action Plans provided) revealed the following trends: • Zero of six (0%) Risk Action Plans were adequate to meet all of the individuals' high and medium risk ratings. The Risk Action Plans did not consistently include plans for all identified high and medium risk ratings. The plans contained some basic action steps to address the high and medium risk ratings, but failed to include all relevant action steps to adequately address the risk ratings, nor were all relevant disciplines included in the action steps. For high and medium risk ratings that should have had nursing HMPs, were rarely referred to in the Risk Action Plans, nor	

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		were other relevant disciplines' plans referred to. Therefore, the Risk Action Plans were not adequately integrated. Examples: o Individual #114's Risk Action Plan did not include action steps to address high risk rating for weight, secondary to weight in relation to congestive heart failure. The action steps did not include a reference to nursing HMPs or other discipline specific plans for high and medium risk ratings. o Individual #177's Risk Action Plan did not include action steps for medium and high risk ratings for weight, fall, fractures, skin integrity, and urinary tract infections and other related infections. The action steps did not include a reference to nursing HMPs or other discipline specific plans for high and medium risk ratings. o Individual #129's Risk Action Plan did not include action steps for habilitation services for high risk ratings for aspiration, respiratory compromise, and osteoporosis, medium risk ratings for falls, fractures, and skin integrity. Action steps were not included for the dietitian related to high risk ratings for weight. The action steps did not consistently include a reference to nursing HMPs or other discipline specific plans for other high and medium risk ratings. o Individual #331's Risk Action Plan did not include action steps for habilitation services for medium risk ratings for osteoporosis and falls. Neither were action steps included for the dietitian related to high risk for overweight. The action steps did not include a reference to nursing HMPs or other discipline specific plans for high and medium risk ratings. o Individual #392's Risk Action Plan did not include a reference to nursing HMPs or other discipline specific plans for high and medium risk ratings. o Individual #336's Risk Action Plan did not include a reference to nursing HMPs or other discipline specific plans for high and medium risk ratings. The At Risk Individuals Policy and instructions required the relevant disciplines to complete their risk assessments 10 days prior to the ISP date and make them available to the RN Case Managers to review in collaboration with the responsible physicians. Then, the RN Case Managers aggregate the assessment data into draft Integrated Risk Rating Forms to be used at the ISP meetings to review, discuss, and determine risk ratings. According to interviews with Nursing Administration and RN Case Managers, with possibly the exception of habilitation services, the disciplines do not provide their assessments within 10 days prior to the ISP meeting dates, if at all. Because the disciplines' risk assessment were not submitted timely to the RN Case Managers, valuable assessment data may not be included, or may be overlooked, in the draft Integrated Risk Rating presented at the ISP. If this happens, it could result in inadequate/inaccurate risk ratings for the individuals.	

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		It is essential that disciplines responsible for their respective risk categories complete comprehensive risk assessments of individuals' overall health status though collaboration with other relevant disciplines, including interviews with the individuals' direct care professionals, and a thorough review of clinical records. The assessment should be completed at least 10 days prior to the ISP meeting dates and submitted to the respective RN Care Managers. The RN Case Managers should corroborate their risk assessment findings with respective physicians prior to the ISP meetings to ensure that all medical, mental and behavioral health related risk factors are identified and the risk ratings are comprehensive, integrated, and accurate. Establishing a competent and reliable risk rating 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 Provisions M.2 and M.3 for additional information related to nursing assessments of risks and health care plans. The Facility should ensure that: 1. Each discipline responsible for their respective risk categories complete comprehensive risk assessments of individuals' overall health status through collaboration with other relevant disciplines, including interviews with the individuals' direct care professionals, and a thorough review of clinical records. The assessments should be completed at least 10 days prior to the ISP meeting date and submitted to the respective RN Case Managers. 2. The RN Case Managers should corroborate their risk assessment findings with respective physicians prior to the ISP meetings to ensure that all medical, mental and behavioral health related risk factors are identified and the risk ratings are comprehensive, integrated, and accurate.	
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	<u>Facility Self-Assessment for Section M.6:</u> The Facility engaged in the following activities in conducting its Self-Assessment for this Provision: • The completed monitoring tools for Medication Administration and Documentation were reviewed. • PNMPs were reviewed to ensure they included a section for medication administration information. • Nurse Managers reviewed nursing signature sheets to ensure unit nursing secretaries updated nursing signature sheets or medication administration with current employees as of 2/01/2012. • Reviewed summaries of medication variances during the Pharmacy and Therapeutics committee meetings. • Nurse Managers reviewed medication variance reports prior to Medication Variance Committee meetings to ensure they were completed correctly and to ensure that	Noncompliance

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	compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	prompt corrective action was taken. • Inter-rater reliability data for Medication Observations were reviewed. The Facility's Self-Assessment reported the following: • The Medication Administration and Documentation Monitoring Tools remained above the 85% threshold, with the third quarter data reported at 98.5% and the fourth quarter data reported at 98.2%. • The PNMPs were updated with medication administration information prior to the next annual ISP. • The Nurse Managers provided a summary of updated nursing signature sheets to Nursing Operations Officer. • The Chief Executive Nurse provided Medication Variance data to Pharmacy and Therapeutics Committee. • The Nurse Managers provided and discussed summary reports for medication errors/variances during the Medication Variance Committee Meetings. • Inter-rater reliability data for medication administration observation were not available at the time of the Self-Assessment. Based on the findings from its Self-Assessment, the Facility determined this Provision was not in substantial compliance because an inter-rater reliability system developed by the nursing department in collaboration with the Quality Assurance department to ensure the accuracy of the medication administration observation data had not been implemented. <u>Monitoring Team's Findings</u> The Facility's Section M Self-Assessment stated they were not in substantial compliance with this Provision and the Monitoring Team concurred. Review of Section M Self-Assessment, Section M Presentation Book, staff interviews, and review of documents, found evidence that the Nursing Department had continued to make steady progress toward achieving compliance in this Provision. Further, the review of this Provision found evidence that validated the Facility's Self-Assessment activities, reported data, and findings upon which they based their status of noncompliance. The Unit Nurse Managers and/or RN Case Managers continued to conduct quarterly Medication Administration Observations. The completed Medication Administration Observation data were reported monthly to the Quality Assurance Department, who analyzed the data and prepared monthly reports by Unit/Infirmary, as well as Facility-wide. The Monitoring Team reviewed Quality Assurance data for the Medication Administration Observations, 8/2011 through 2/2012. This data showed progressive improvement from the last compliance review. The reports provided the following	

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		percentages for monthly compliance with the monitoring tools: • August - 97% • September - 95% • October - 98% • November - 97% • December – 97% • January – 93% • February – 98% The QA Department compiled monthly reports for the overall percentage of compliance found for Medication Administration Observations, which included the following information: Number of nurses observed and highlighted items falling below 100%. The reports were sent to Unit/Infirmary Nurse Managers and Nursing Administration for review. The results of the Medication Administration Observations were discussed and corrective action was taken for items found deficient at the various Units/Infirmary Nursing Meetings and the outcome of the meetings presented at the Medication Variance Committee Meetings for further discussion and corrective action when indicated. This was verified through a review of the various Monthly Nursing Meetings and Medication Variance Committee Meeting minutes. A review of the QI/QA Council Meeting: Data Analysis Report, 2/21/12, reported that the Medication Administration and Documentation data showed overall compliance of 98.2% for the quarter of November, December and January, 2012. The only area falling below the 85% standard for compliance was M-MAD-EA.8 which was 75% for stoma care provided. There was no documentation of a CAP, if one was initiated, to review for this item falling below 75% compliance. According to the Facility's Criteria for Writing a Corrective CAP, data falling below 85% percent required a CAP. As reported in the Facility's Self-Assessment, an inter-rater reliability system developed by the nursing department in collaboration with the Quality Assurance department to ensure the accuracy of the medication administration observation data had not been implemented. The Monitoring Team's Nurse Monitor and PNM Monitor accompanied the CNE, NOO, Unit Nurse Manager, and State Office Nursing Coordinator, during the medication administration observations conducted in Houston Park Apartments 13B and 13 C, at noon on 4/5/12. The apartments continued to lack medication rooms from which to administer medications that would afford individuals with privacy and limit distractions for the nurses. For individuals who received oral medications, they were administered in a hallway that was determined to have the least amount of interruption and used a	

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		privacy screen to provide some degree of privacy. For individuals who received medications enterally, they were taken to a private room. The Home Manager was present during the observation and assisted with ensuring that direct care professionals assisted the nurses while they administered medications. Unlike Building 528 for Apartments A, B, C, and D, where medication administration observations were conducted at the last review, and where the Facility had created medication rooms converted from closets, these apartments had not converted closets into medication rooms. The Facility should consider the risk and benefits of having closets versus medication rooms where individuals could receive medications in privacy and distractions could be eliminated to prevent medication errors/variances. The nurses administering medication consistently reviewed the Medication Administration Instruction Sheet and PNMP for each individual prior to administering medications. However, not all individuals had a revised PNMP that provided medication administration strategies according to the prescribed dining techniques, use of adaptive equipment, positioning, and number of pills that can be safely tolerated at one time. Individuals' PNMPs were being revised at their annual ISP. Even PNMPs that had been revised did not include in the medication administration instructions for all information contained in the dining instructions to assist the nurses safely administers medication. For example, one individual observed required an adaptive cup according to the dining instructions but a regular drinking cup was used for medication administration because it was not included on the medication administration instructions. The PNM Monitor explained to the nurse the rationale for needing to use the adaptive cup. It was apparent from the observations that the PNMPs should also include all of the strategies included on the other parts of the PNMP to ensure safe oral intake or other special strategies related to enteral administration. It is important for this information to be included in the medication administration instructions in order to make it readily accessible to the nurses during heavy mediation passes when time is limited and they do not have time to review the entire PNMP to identify all strategies to administer medication safely. It was also apparent that the nursing staff could profit from enhanced dysphagia training, such as the Dysphagia Training that the PNM nurses receive, to help them better understand the rationale for the strategies contained in the PNMPs for safely administering medications orally and enterally. Refer to Provision O.3 for additional information. Other than the issues identified with regard to the PNMPs, the nurses followed correct administration practices with one exception. When observing individuals administering enteral medications, the nurse did not remove the gauze surrounding the stomas to assess and clean the stomas. Because of the high incidence of G/J tubes leaking and having cellulitis, as found and reported in the wound care, infection control, and QA data where compliance was only met by 75%, it is essential that the nursing staff	

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		administering medications enterally also strictly adhere to stoma assessments and care practices. The Control Drug Logs were checked and found that 13B logs did not consistently contain two nurses' signatures for shift to shift counts on 6-2 and 2-10 shifts. The State Office Nursing Coordinator said the Pharmacy Policy only required daily counts; however, shift-to-shift counts were done using a standard form, but this was not done all the time. The purpose of checking control drugs by on coming and off going nurses each shift is to ensure the security of the control drugs. DADS may wish to review policy, and the Facility should determine the practice to be done and ensure it is done consistently. The storage room for stock medications and the refrigerator was located in another building because of lack of storage area in the homes. There were no expired medications found in the storage room but the medication refrigerator temperature had not been checked since March, 2012, and then it was only checked one day for the month. The temperature gauge read between 33 and 34 degree Fahrenheit (F). Standard temperature range for refrigerators is between 35 and 46 degrees F with the aim to maintain temperatures at 40 degrees F. Checking the medication refrigerators temperatures where nurses store medications was discussed with the Chief Pharmacist. She said the Pharmacy only checked the refrigerators in their area. The nursing staff were responsible for checking the refrigerator temperature in areas where they store medications. It is essential that the nursing staff checks and records the temperatures of the medication refrigerators daily and requests maintenance checks for any variability from the acceptable temperature range; because storing medications above or below the recommended temperature my cause the medications to breakdown and lose their effectiveness and/or expire before the expiration date. Any problems identified should be reported through the Facility's medication variance process. Since the last compliance review the Facility had continued to record medication variances into a Medication Variance 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 variance represented, and had a color-coded legend explaining the graphs. This data provided the Facility with detailed medication variance information from which to make decisions for corrective action to reduce the incidents of variances. The Monitoring Team was provided with medication variance data 9/2011 through 11/2011 that had been analyzed and trended. The data graphs did not include a summarized narrative that would assist the reader in interpreting the data.	

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		At the last review the Facility had just adopted and was beginning to implement the DADS Medication Variance Policy, 053. In order to identify the broad array of medication variances, they had revised the DSSLC Pharmacy Policy, Number 27.1, on 2/15/12, to include changes to Medication Variance Tracking and Procedures. The purpose was to: Identify and report all actual variances within departments to identify trends, and implement process to improve safety of individuals served; enhance staff knowledge about safe medication use processes; learn from medication variances by creating a culture of voluntary non-punitive reporting; and collect, aggregate, and analyze medication variance data to identify systemic safety issues. It was impressive to find that the nursing staff were reviewing monthly medication variance reports for each Unit/Infirmary variances by type of variance, by the nurse committing the variance, and by total number of variance that occurred, and had calculated the rate of occurrence based on the total number of medications administered by Unit/Infirmary. The data were critically analyzed for trends campus-wide, discussed, conclusions drawn based on the findings, and plans of correction were developed and implemented. The committee also reviewed, analyzed, trended, discussed, drew conclusions and developed plans of corrective action for Pharmacy near misses, variances, and potential adverse drug reaction, as well as for QA Medication Observations. Other substantive medication administration practices were also reviewed, discussed, and plans of corrective action developed when indicated. Through a review of the data, the Monitoring Team was able to identify the overall monthly number of nursing medication variances as listed below: • September – 32 • October - 42 • November – 54 Medication variances for December, 2011, January, February and March, 2012 were not summarized as above and were still being analyzed. However, medication variance data were analyzed and reported for 1/2011 through 12/2011, and revealed the following information: The most common type of medication variance was omissions, which accounted for 242 of 459 (53%) of all variances made in the last year. The most common reason for the variances was distraction, accounting for 152 (33%) variances, 84 (18%) variances were made by inexperienced and/or agency staff. The summary did not include a systemic corrective action plan. A review of the Medication Variance Committee meeting minutes since the last review, and the attendance at the 4/4/12 Committee meeting, demonstrated it was still maturing and the members were still determining what data to collect, analyze, and represent to make it meaningful in improving medication administration practices. The Committee	

#	Provision	Assessment of Status	Compliance
		had a good structure that was chaired by the Chief Pharmacist and had an integrated membership of all relevant disciplines who actively participated in discussions, problem solving, corrective and follow-up actions. Information from the Medication Variance Committee was submitted to the Pharmacy and Therapeutics Committee meetings for further review and action when necessary. This was validated through a review of the Pharmacy and Therapeutics Committee meeting minutes and attendance at the 4/3/12 Committee meeting. The Infection Control Preventionist continued to summarize and report epidemiological data to the Pharmacy and Therapeutic Committee regarding specific infections, and the sensitivity/effectiveness of the response to antibiotics prescribed to treat specific organisms. The Monitoring Team will continue to review compliance with the Medication Variance Policy at the next review. Refer to Section N for more information regarding medication administration practices. Although there had been improvements and progress had been made toward meeting compliance, 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 ensure: • The Action Plan's action steps that have not been started or are still in process are completed. • The nursing staff receives enhanced dysphagia training, such as the Dysphagia Training that the PNM nurses receive. • The nursing staff checks and records the temperatures of the medication refrigerators daily and requests maintenance checks for any variability from the acceptable temperature range. • The nursing staff administering medications enterally should also strictly adhere to stoma assessments and care practices.	

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

1. The Nursing Department should: (Provision M.1)
    - 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.
2. The Nursing Department should continue to monitor compliance with all Nursing Policies, Procedures, and Protocols relating to acute care changes in status, to ensure they are strictly followed. (Provision M.1)
3. The Nursing Department should make the following improvements: (Provision M.1)
    - 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 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.
- 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.
- 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.

4. The Facility should ensure that: (Provision M.1)
    - Full Mock Medical Emergency Drills are completed.
    - Different scenarios are used for conducting Mock Medical Emergency Drills.
    - Physicians and nurse practitioners attend the Mock Medical Emergency Drills.
    - Action steps identified in the Action Plan related to emergency response activities are completed.
5. The Nursing Department should consider a real-time system to notify Infection Control Preventionist of all individuals' diagnosed infections so that she can promptly follow-up and ensure that appropriate infection control interventions are put in place, including an individualized Acute Care Plan, as well as reviewing the quality of the assessments and documentation, and to provide consultation and training when deficiencies are identified. (Provision M.1)
6. The Nursing Department should ensure: (ProvisionM.2)
    - The completion of the Action Plan's action step for ensuring that the RN Case Managers change Annual and/or Quarterly Nursing Assessment schedules when they are revised by the QDDPs.
    - That nursing problem/diagnoses and accompanying HMPs are developed and implemented for all of individuals' high and medium risk ratings that require nursing interventions.
    - That a standardized format is used for writing overall nursing summaries.
    - The implementation and training of the RN Case Managers on the revised Admission and Discharge to Community or Other Facilities Nursing Assessment form.
    - The Nursing Department needs to implement and train the RN Case Managers on the revised Admission and Discharge to Community or Other Facilities Nursing Assessment form.
    - The Nurse Case Managers complete an addendum to the Quarterly Comprehensive Nursing Assessment when there are changes in individuals' risk ratings or other significant changes in health status, and revise and/or develop and implement HMPs for changes in status.
7. The Nursing Department should ensure the following: (Provision M.3)
    - HMPs address all high and/or medium risk indicators and active problems that require nursing interventions.
    - HMPs are individualized to meet individuals' specific health care needs in relation to their identified risks and/or active medical problems.
    - HMPs are reviewed and/or revised at the time of the quarterly/annual nursing assessment or when there was a change in health status.
    - ACPs and HMPs include proactive/preventative measures to reduce and/or eliminate risk indicators/problems.
    - ACPs and HMPs contain integrated interventions in collaboration with other relevant disciplines, as required in Sections G and F of the Settlement Agreement.
    - ACPs and HMPs include who would implement the nursing interventions, how often they would be implemented, where they were documented, and how often they would be reviewed and/or revised.
    - When the functional HMPs in the Red Care Plan Books are revised, the original HMPs in the unified records are also revised.
    - When the active ACPs kept in the Units/Homes' Red Care Plan Books are resolved they are removed and filed in the unified records.
8. The Nursing Department and the Nurse Educators should reinforce and monitor the nursing practices contained in Nursing Policies, Procedures, Processes and Protocols, to ensure they demonstrate actual clinical practices sufficient to address the health status of individuals served. (Provision M.4)
9. The Facility should ensure that: (Provision M.5)

- All disciplines responsible for their respective risk categories complete comprehensive risk assessments of individuals' overall health status through collaboration with other relevant disciplines, including interviews with the individuals' direct care professionals, and a thorough review of clinical records. The assessments should be completed at least 10 days prior to the ISP meeting dates and submitted to the respective RN Case Managers.

10. The RN Case Managers should corroborate their risk assessment findings with respective physicians prior to the ISP meetings to ensure that all medical, mental and behavioral health related risk factors are identified and the risk ratings are comprehensive, integrated, and accurate.
11. The Nursing Department should ensure: (Provision M.6)
    - The Action Plan's action steps that have not been started or are still in process are completed.
    - The nursing staff receives enhanced dysphagia training, such as the Dysphagia Training that the PNM nurses receive.
    - The nursing staff checks and records the temperatures of the medication refrigerators daily and requests maintenance checks for any variability from the acceptable temperature range.
    - The nursing staff administering medications enterally should also strictly adhere to stoma assessments and care practices.

The following are offered as additional suggestions to the Facility:

1. The State Office should consider revising the Health Care Guidelines, particularly as relates to the Preventative Health and Immunization Sections. (Provision M.1)
2. Add polio vaccination information to the Comprehensive Nursing Assessment template.
3. Provide the Nursing Department with technical assistance from an expert to provide competency-based training to assist the relevant nursing staff with critically analyzing clinical data into clear and concise summaries reflective of individuals' health status.
4. For future diabetic trend studies, the Diabetic Educator Nurse should consider collaborating with the Facility medical staff and consulting endocrinologist to evaluate lowering the hyperglycemia indicator to 200 to 230 mg/dL's. (Provision M.1)
5. The Facility should consider the risks and benefits of having closets verses medication rooms where individuals could receive medications in privacy and distractions eliminated to prevent medication errors/variances. (Provision M.6)

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. Self-Assessment, dated 3/16/12 2. Presentation Book 3. Most recent new order scripts, past 12 months labs, medication list, and problem list for Individuals #50, #551, #202, #60, #192, #167, #151, #1, #85, and #117 4. Most recent script and Single Patient Drug Intervention Report, along with supporting documentation by physician for Individuals #474 (two reports), #5, #89, #526, #731, #757, #144, #466, and #295 5. Revised procedure for inpatient medication dispensing, Pharmacy Policy #39, revised April 6, 2012 6. Competency training signoff sheet for training on dispensing procedure, dated 4/6/12 7. Most recent QDRR, 12 months labs, problem list, vitals and abdominal girth, physician review of QDRR for Individuals #553, #488, #616, 297, #562, #725, #610, #151, #579, and #257 8. Benzodiazepine Policy Guidelines, PP 48, dated 6/1/11 9. Anticholinergic Policy and Procedure, PP 48, dated 12/5/11 10. Polypharmacy Review Committee Policy, dated 2/7/12, no identifying number assigned 11. Policy for Adverse Drug Reaction Reporting, dated 2/28/12, pp. 34.1 12. DSSLC Drug Utilization Policy, dated 7/8/11, PP #35.1 13. Drug utilization for Calcium supplements, and flouroquinolones 14. P&T Committee Meeting Minutes, dated September 2011, and January 2012, 15. Drug Utilization Evaluation (DUE) Calendar for 2012 & 2013 16. Medication Variance Tracking Procedure, dated 2/15/12, PP 27.1 17. Minutes from Medication Variance Committee Meetings from 10/11 through 1/12 18. Copy of Medication error reports, summaries, and data from 10/11 through 1/12 19. Medication Variance Review Committee Procedure, Policies & Procedures Manual 23, dated 8/9/11 20. DSSLC ADR Policy, 2/28/12 **People Interviewed:** 1. Jana Boone, R.Ph. Pharmacy Director **Meeting Attended/Observations:** 1. Abbreviated P&T Committee Meeting 2. Abbreviated Polypharmacy Committee Meeting
	Facility Self-Assessment: The Facility reported in its self-assessment that it was in substantial compliance with all provisions of Section N, except for Provision N.4. The Monitoring Team concurred with the Facility's self-assessment with substantial compliance for Provisions N1, N.2, and N.3, and non-compliance for Provision N.4; however, the Monitoring Team disagreed with the Facility's self-assessment of compliance for Provisions N.2, N.3, N.5, and N.8. Although the self-assessment for Provision N.2 identified that QDRRs were completed timely, QDRRs did

	not include an assertive review of, or offer recommendations on, how to reduce the use of benzodiazepines, polypharmacy, anticholinergics, and it did not assertively address metabolic syndrome. The pharmacy department is cognizant that a serious deficit remains in the area of metabolic syndrome. Importantly, the Monitoring Team reviewed QDRRs in the context of generally accepted standard of care, and the Monitoring Team determined that the QDRR process did not meet such standards of care. As with the self-assessment for Provision N.3, the Monitoring Team concurs with most of the self-assessment; however, as with Provision N.2, the Facility did not assertively address metabolic syndrome. Regarding the self-assessment for Provision N.5, the Monitoring Team reviewed and assessed side-effect monitoring in Provision J.12 and determined that side effect screening was not being accomplished when clinically necessary, and inter-rater reliability by nurses required enhancement. The self-assessment for Provision N.8, was mostly correct; however, it did not comment of the rate-limiting involvement by physician services. Physicians must actively participate in the medication variance process at the Facility.
	Summary of Monitor's Assessment: The Monitoring Team would like to compliment the Facility, and the Director of Pharmacy for the exceptional level of dedication in working towards compliance for Provision N. Following review of this report, the reader should appreciate that only minor enhancements are needed in the areas determined not in compliance, to become compliant. Provision N1. Review of new medication orders, follow-up documentation by the pharmacist, and the newly revised procedure for medication dispensing indicated that the pharmacy is appropriately assessing new medication orders, indicated that they have reviewed each script for appropriateness, need for laboratory assessments, and side effects, and that when necessary, physicians appropriately address pharmacists' recommendations. For these reasons the Monitoring Team determined that the Facility is in compliance with Provision N.1. The Monitoring Team understands that the Facility has experienced a significant physician staff turnover, and that newly hired physicians are being trained on how to appropriately address pharmacy recommendations. Assessment of physician follow-up to pharmacy recommendation is addressed in Provision N.4, of this report. Provision N2. The Monitoring Team noted that the Clinical Pharmacists had significantly improved the overall quality and timeliness of the QDRR process. It is evident that a more thorough review had taken place, and follow-up to recommendations was clearly evident, and physician follow-up on recommendations was determined to be significantly improved since the last review period; however, because the QDRR process did not adhere to acceptable standard of care practice, the Provision remains noncompliant. The following omissions will need to be rectified before compliance for Provision N.2, can be achieved: 1. QDRRs must rely on clinical data, such as laboratory studies, body weight, vitals, and abdominal girth, from the same quarter in which the QDRR is being performed. 2. A comprehensive assessment for metabolic syndrome must be completed for each QDRR. 3. The pharmacists must assess and document pharmacotherapy effectiveness and possible side effects. 4. Ensure that medications are being used appropriately for dose and indication.

	5. Ensure that the use of polypharmacy, benzodiazepines, anticholinergics, and STAT psychotropic medication use is clearly delineated on the QDRR, and that the pharmacists provide review and recommendations for such use. Provision N3. In general, the pharmacy department, under the leadership of the pharmacy director and with collaboration by the clinical pharmacist, dispensing pharmacists, and prescribing clinicians, have done a remarkable job in pulling together a robust mechanism to assess and address clinical issues related to the use of sedating benzodiazepines, polypharmacy, and STAT medication use. Appropriate data elements are being collected, analyzed and reported to committees, and acted upon. There have been modest improvements with the use of polypharmacy, and greater then modest results in the use of benzodiazepines, STAT medication use, and anticholinergics. Nevertheless, the Monitoring Team determined that the Facility is noncompliant with Provision N3. Before compliance can be achieved, the Facility must ensure that metabolic syndrome is assertively monitored and managed once diagnosed, and when risk factors are known. The Facility does not collect important data, including periodic glucose monitoring and measurement of abdominal girth. Metabolic syndrome should be assessed at least quarterly for individuals on antipsychotic medications. Results should be clearly delineated on the QDRR, along with appropriate clinical recommendations. In addition, system wide data should be assessed, summarized, and reported to a committee for recommendations. Also, the use of benzodiazepines, anticholinergics, polypharmacy, and the STAT use of medications must be delineated in the context of the QDRR review process. The Monitoring Team would like to compliment the pharmacy department for inclusion of non-psychotropic medication use when reviewing STAT medication use by the Facility. This enables a qualitative, and quantitative review of all STAT medication use by the Facility, and will greatly enhance medical care in the area of seizure disorder and diabetes. Provision N4. Because physicians are not appropriately documenting an action plan for pharmacy recommendations, the Monitoring Team determined that Provision N.4 is noncompliant. Compliance will require that physician staff appropriate document their responses to pharmacy recommendations, and document a clinically rational action plan to address the pharmacists concern. Provision N5. Because the side effect monitoring is assessed by section J.12, please refer to section J.12 of this report for a summary review of Provision N.5. Provision N6. Because of the high quality of Adverse Drug Reaction (ADR) monitoring, tracking, analyzing and reporting, the Monitor Team determined that the Facility is in compliance with Provision N6. Subsequent reviews will include review of training records to ensure that new staff are trained on the reporting practice for ADRs. The Monitoring Team compliments the pharmacists, nurses, direct care staff, and physicians who helped develop and implement this process, and who assertively monitor individuals for ADRs.

	Provision N7. The Pharmacy Department maintains a robust Drug Utilization Evaluation (DUE) process that is supported by policy, and demonstrated by the Monitoring Teams review of completed DUEs. For these reasons, the Monitoring Team determined that the Facility is in compliance with Provision N7. Provision N8. The Facility had developed, and partially implemented a robust, high quality, medication variance process, that included full participation by the pharmacy, physician, and nursing departments. Despite meaningful participation by nursing and pharmacy staff, physician services did not participate at the medication variance committee meetings, did not assertively address medication variances through its own physician provider committee, nor did it provide the medication variance committee with suggestions on how to remedy prescriber variances. For these reasons, the Monitoring Team determined that the Facility remains not in compliance with Provision N.8. Compliance will require assertive participation by physician service in the medication variance process.

#	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 use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	This provision assesses the Facility's processing of medication orders to ensure that pharmacy reviews each order for completeness, appropriate dosing and side effects and the need for laboratory monitoring of drug levels. The Monitoring Team selected the last 10 scripts written that did not require a single patient drug intervention (SPDI), beginning on the day prior to the Monitoring Team visit, and the most recent 10 scripts written that required a SPDI, beginning on the day prior to the Monitoring Team visit. The revised policy for in patient dispensing, along with evidence that staff were trained on the policy was reviewed. In addition, the database for all SPDI was reviewed for completeness and appropriateness for the past six months. **Inpatient Medication Dispensing Procedure:** The pharmacy updated its dispensing procedure to ensure that pharmacists verify that current lab values for medications are reviewed when necessary, and to assess for potential toxicity per lab review. All pharmacy staff were trained on the new policy. The Monitoring Team determined that the Facility's policy on medication dispensing is appropriate, and following review of 20 most recent scripts, determined that the Facility is following its procedure. Ten Most 10 Recent Scripts For New Prescriptions That Did Not Require SPDI: The most recent scripts written for processing of a new order that did not require a SPDI were reviewed (Individuals #50, #551, #202, #60, #192, #167, #151, #1, #85, and #117) to ensure that the pharmacy appropriately assessed each script for appropriate labeling, time, date, medication indication, need for laboratory monitoring, appropriate dose, duplicate order, and side effects.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The Facility had a requirement in policy for review and for documentation by pharmacist signature/initial that the review had occurred. At the time of processing a prescription, the pharmacist opens the individual's profile on the WORx computer system, and by referring to the individual's profile with the new script, assesses the appropriateness of the medication, and identifies if there is deficiency with the order or alerts, such as side effects. Of the 10 scripts reviewed 10, out of 10 (100%) were labeled correctly; 10, out of 10 (100%), indicated an appropriate diagnosis (100%); 3, out of 3 (100%) which would require lab monitoring had appropriate lab monitoring ordered; and 10, out of 10 (100%) had the pharmacist's initial on the script, indicating that they reviewed the script per procedure. Ten Most 10 Recent Scripts For New Prescriptions That Required SPDI: The most recent scripts written for processing of a new order that required a SPDI were reviewed (Individuals #474 (two reports), #5, #89, #526, #731, #757, #144, #466, and #295) to ensure that an appropriate SPDI was initiated by pharmacy, that the physician addressed pharmacy concerns, and that there was documented evidence to support appropriate follow-up by the physician, but no evidence of the physician documenting an action plan. That is, the pharmacist reviewed whether action had been taken and provided the Monitoring Team with documentation of physician orders or of pharmacist statements that recommendations were followed and completed; at other facilities, physicians are expected to write action plans, but this was not done at DSSLC. Of the 10 most recent scripts reviewed that would require a SPDI 9 (90%) had appropriate documentation by means of an email, note, or SPDI form by the pharmacist, that clearly delineated the issue, and made appropriate recommendation to the physician; 0 (0%) of the examples had actual documentation by the physician of an action plan to address the pharmacists, recommendation; however, 8 out of 10 (80%) of examples had other evidence, such as a medication order, or order to monitoring an individual, that indicated that the pharmacists recommendation was followed. **SUMMARY:** Review of new medication orders, follow-up documentation by the pharmacist, and the newly revised procedure for Medication Dispensing indicated that the pharmacy is appropriately assessing new medication orders, indicated that they have reviewed each script for appropriateness, need for laboratory assessments, and side effects, and that when necessary, physicians appropriately address pharmacists recommendations. For these reasons the Monitoring Team determined that the Facility is in compliance with Provision N.1. The Monitoring Team understands that the Facility has experienced a significant physician staff turnover, and that newly hired physicians are being trained on how to appropriately address pharmacy recommendations. Assessment of physician follow-up to pharmacy recommendation is addressed in Provision N.4, of this report.	

#	Provision	Assessment of Status	Compliance
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.	This provision deals with the pharmacy's review of medications through its quarterly drug regimen reviews (QDRR). The Monitoring Team requested the last 20 completed QDRRs from home 526, and reviewed the first 10 QDRRs (Individuals #553, #488, #616, 297, #562, #725, #610, #151, #579, and #257), and associated documentation, for completeness. Provision N.2, requires that the pharmacist review, consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values. The Monitoring Team assessed QDRRs to ensure that they met, or exceeded community standard of care practice, and used the CMS Medication Regimen Review Guide, dated 2006, as a reference to assess compliance. Specific issues assessed included: • Timeliness of the QDRR • Laboratory review (including blood values, DEXA studies, and EKGs), • Vital signs • Review of weight and abdominal girth • MOSES and DISCUS assessments • Pharmacy recommendations • Assessment of side effects, • Appropriateness of recommendations • Response and action plan by the prescribing physician • STAT medication use • Use of benzodiazepines, anticholinergics, and polypharmacy Of the 10 QDRRs reviewed 9 were timely (90%); vital signs and weight were assessed by review of the nursing assessments in 10 (100%) cases; drug levels were assessed appropriately in 10 (100% cases); metabolic syndrome was assessed in 0 (0%) cases; EKGs were completed timely in 10 (100%); review for drug efficacy was evident in 0 (0%) cases; review of side effects was evident in 0, out of 10 (0%) cases; Pharmacists made appropriate recommendations, based on the issues reviewed for the QDRR, in 10 (100%) cases; Physicians appropriately addressed pharmacists recommendations in 9 (90%); however, Physicians appropriately documented their action plan for the QDRR recommendations in 0 (0%), of the examples. <u>Summary</u> The Monitoring Team noted that the Clinical Pharmacists had significantly improved the overall quality and timeliness of the QDRR process. It is evident that a more thorough review had taken place, and follow-up to recommendations was clearly evident, and physician follow-up on recommendations was determined to be significantly improved since the last review period; however, because the QDRR process requires the following items to be addressed in order to adhere to acceptable standard of care practice, the	Noncompliance

#	Provision	Assessment of Status	Compliance
		Provision remains noncompliant. The following omissions will need to be rectified before compliance for Provision N.2, can be achieved: • QDRRs must rely on clinical data, such as laboratory studies, body weight, vitals, and abdominal girth, from the same quarter which the QDRR is being performed. • A comprehensive assessment for metabolic syndrome must be completed for each QDRR • The pharmacists must assess and document pharmacotherapy effectiveness and possible side effects • Ensure that medications are being used appropriately for dose and indication • Ensure that the use of polypharmacy, benzodiazepines, anticholinergics, and STAT psychotropic medication use is clearly delineated on the QDRR, and that the pharmacists provides review and recommendations for such use	
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.	This provision deals with the Facility's management of the use of STAT medications, benzodiazepine use, the use of anticholinergics, and polypharmacy. <u>Review of STAT Medication Use</u> The Facility maintained an effective practice of tracking and analyzing all STAT medication use at the Facility, for both psychotropic and non-psychotropic medications. Each incident is recorded on an excel spreadsheet document in the pharmacy department. The chief pharmacist tracks and trends STAT medication use, and presents a summary to the Pharmacy and Therapeutics Committee (P&TC). When necessary, the P&TC will decide upon action steps. Whenever there is an administration of a STAT psychotropic medication, the Facility's polypharmacy policy requires comprehensive documentation of the clinical rationale for its use, potential side effects, drug interactions and recommendations on the Face-to-Face, Chemical Restraint Form. The chief pharmacist reported to the Monitoring Team that a trends analysis, which would include a summary, would be documented for the use of all STAT psychotropic medications, and be presented to P&T. During this review period, there were no STAT psychotropic medications administered. The use of STAT medications other than psychotropics includes medications to treat hypoglycemia, and seizures. During the previous quarter (October, November, and December), a total of 32 doses of Diastat were administered to 15 unique individuals. At total of 37 doses of dextrose gel or glucagon were administered to 11 unique individuals, during the previous quarter. The use of these medications, along with a trends summary were provided at the January 29, 2012 P&T Committee. The committee forwards copies of the trends analysis to prescribing physicians and the diabetic educator nurse, who incorporates the data in their treatment plans. The Facility is currently converting their data management process from an Excel Spreadsheet to an actual database.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Review of Benzodiazepine Use The Monitoring Team reviewed the Facility's Policy Guidelines for benzodiazepines, which indicates that the pharmacy department will collect data on benzodiazepine use and review with the health care teams. The use of benzodiazepines was reviewed by the chief pharmacist and presented to the P&T committee each quarter. The date elements and trends analysis is presented along with a summary of the data. During the last quarter, the Facility reported that a total of 42 individuals were prescribed routine administration of a benzodiazepine, which was an increase from the previous quarter, and represents 8% of the total residential population at the Facility. Eleven out of 42 (26%) individuals received benzodiazepines for neurological conditions, such as spasticity, and tremors; five out of 42 (12%) were prescribed for seizure related conditions; and 26 out of 42 (58%) were prescribed for psychiatric issues, such as insomnia, and anxiety. The increase in the total number of individuals administered routine prescribed benzodiazepines is secondary to a new admission, who was admitted to the Facility on a benzodiazepine, an individual who was recently diagnosed with cancer and suffered from anxiety, and a third individual who was prescribed a benzodiazepine for myoclonic jerks. The use of benzodiazepines was appropriately discussed at the January 2012 P&T Committee per review of the committee minutes. Review of Anticholinergic Use The anticholinergic policy, and procedure was reviewed, and noted that at the time of the QDRR, the pharmacist will list all anticholinergic medications, and when possible, suggest alternative therapeutic options with lower anticholinergic effects. The policy also states that the Facility will review anticholinergic polypharmacy in the monthly polypharmacy meetings, and that a trends analysis of polypharmacy will be reported at least annually at the P&T committee. During its review of QDRRs for Provision N2, the Monitoring Team did not see a formal review of anticholinergic medications, or consideration for the use of medications with less anticholinergic properties. The Facility needs to ensure comprehensive assessment of anticholinergics in the QDRR process. The Pharmacy summarized the use of anticholinergic medications each quarter. Review of data on anticholinergic use for July, October, and January 2012 indicated that the use of anticholinergic medications continued to decrease over time, with decreased total use of anticholinergics for psychiatric and general medical purposes. Also noted was a robust decrease in the number of individuals who were prescribed intra-class	

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		anticholinergic medications, and individuals who were prescribed two or more anticholinergic medications. Review of Polypharmacy Medication Use The Facility developed a policy for its polypharmacy review committee. The Policy describes committee membership, and reporting responsibilities of the committee, and how data will be collected and analyzed. The policy did not describe how polypharmacy would be addressed through the QDRR process. The Monitoring Team expects full review and formal recommendations be delineated on the QDRRs. The pharmacy maintained excellent data elements specific for polypharmacy use at the Facility, that indicated modest improvements, with a reduction of people taking four or more psychotropics reducing from February 2011, through February 2012, intraclass polypharmacy decreased by 7 individuals; individuals prescribed 3 psychotropics increased by 12; individuals prescribed 4 psychotropics decreased by 2; and individuals prescribed 5 or more decreased by 2 individuals. However, the data for 2012 included addition of individuals who were prescribed anticholinergic and anticonvulsant polypharmacy. Please refer to the table in Provision J11 for detail. The minutes from the September 2011 through January 2012 Polypharmacy Meetings were reviewed, and noted a robust assessment of those individuals who were prescribed psychotropic polypharmacy. Excellent documentation, discussion, and action plans were clearly delineated. Review of Metabolic Syndrome Assessments Standard of care practice dictates that there is assertive monitoring and appropriate action taken whenever an individual is diagnosed with metabolic syndrome, or has risk factors for metabolic syndrome. This is especially true for individuals who are prescribed antipsychotic medications. Following review of the ten QDRRs reviewed in Provision N.2, and after learning from the pharmacy director that the Facility only collects abdominal girths once per year, the Monitoring Team determined that the Facility should review its schedules for monitoring individuals for metabolic syndrome. Summary In general, the pharmacy department, under the leadership the Chief Pharmacist, and with collaboration by the clinical pharmacist, pharmacists, and prescribing clinicians, have done a remarkable job in pulling together a robust mechanism to assess and address clinical issues related to the use of sedating benzodiazepines, polypharmacy, and STAT medication use. Appropriate data elements are being collected, analyzed and reported to committees, and acted upon. There had been modest improvements with the use of polypharmacy, and greater then modest results in the use of benzodiazepines,	

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		STAT medication use, and anticholinergics. Following review, the Monitoring Team determined that the Facility is noncompliant with Provision N3. For compliance to be achieved, the Facility must ensure that metabolic syndrome is assertively monitored and managed when diagnosed, and when risk factors are known. The Facility did not collect important data, including periodic glucose monitoring and measurement of abdominal girth. Metabolic syndrome should be assessed at least quarterly for individuals on antipsychotic medications. Results should be clearly delineated on the QDRR, along with appropriate clinical recommendations. In addition, system wide data should be assessed, summarized, and reported to a committee for recommendations. Also, the use of benzodiazepines, anticholinergics, polypharmacy, and the STAT use of medications must be delineated in the context of the QDRR review process. The Monitoring Team would like to compliment the pharmacy department for inclusion of non-psychotropic medication use when reviewing STAT medication use by the Facility. This enables a qualitative, and quantitative review of all STAT medication use by the Facility, and will greatly enhance medical care in the area of seizure disorder, and diabetes.	
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.	This Provision assesses the prescribing physicians' ability to address concerns raised by the pharmacist when processing a new medication order and completing a QDRR. The Monitoring Team reviewed a total of 10 new medication orders that required a SPDI, as listed in Provision N1, and 10 QDRRs, as listed in Provision N2, of this report. Of the 20 recommendations outlined by the pharmacist, the physician agreed with the pharmacist in 17 examples (85%), but documented an action plan in 0 examples (0%). Psychiatrists did not sign QDRRs to document review, or agreement or disagreement with recommendations. To verify that action was taken to follow recommendations, the Monitoring Team reviewed QDRRs to see what actions were planned and documented. Because physicians were not appropriately documenting an action plan for pharmacy recommendations, the Monitoring Team determined that Provision N.4 is noncompliant. Compliance will require that physician staff appropriate document their responsive to pharmacy recommendations, and document a clinically rational action plan to address the pharmacists concern.	Noncompliance
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a	Information reviewed for this provision was from Sample #1 for Section J. Clinical materials reviewed included annual medical summaries, active problem lists, most recent health risk assessments, the psychiatry section inclusive of the most recent	Noncompliance

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	validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	admission or annual psychiatric assessment, most recent MOSES/DISCUS side effects screening, recent QDRRs, and the most recent neurology consultation. Information about training on use of these instruments can be found in Provision J12. The screening was done by nurse case managers who were familiar with the individual, and the same nurse case managers attended the psychiatry clinic appointments where the results of the screening were reviewed. The Monitoring Team attended psychiatry clinics where screens were reviewed, along with other materials. Facility wide tracking for individuals with high DISCUS scores was reviewed and the Monitoring Team verified that once individuals were diagnosed with tardive dyskinesia, the diagnosis was entered into the record. The Lead Psychiatrist confirmed that the Polypharmacy Committee tracked individuals with known dyskinesia, to assure that proper caution was used regarding the use of these individuals with psychiatric medications that could promote a process of further dyskinesia. The records of the 15 individuals in Sample #1 were reviewed for the presence of required screening. In six of 15 individuals (40%) one or more of the screenings were not provided. To explore the possibility that the side effect screenings had been done but a copy of the document was not provided to the Monitoring Team, the Facility list of all recent evaluations was inspected. The missing screens were not listed on the document. One (Individual #287) was rated on 10/19/11 as having no dyskinesia, but on 1/10/12 the same individual was listed as having persistent dyskinesia. No problems were noted with missing signatures. One of the action steps for this provision on the 3/8/12 Facility Action Plan was to make sure that RN case managers will have the side effect screens reviewed by both the psychiatrist and the primary care physician. There were no difficulties noted on the current visit on these items. However the number of screens that were needed but missing suggested that there was a breakdown in the system for tracking the need to complete the screen. Please refer to section J.12, of this report for recommendations.	
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	This provision assesses the Facility's ability to monitor, and report adverse drug reactions (ADRs). The Monitoring Team reviewed the Facility's newly developed policy for ADR reporting, dated 2/28/12. The policy provided for review appears to be in draft format because there were numerous highlighted areas that require deletion from the document. The policy outlines definitions, staff responsibilities on reporting of ADRs, data collection and reporting on ADRs at the Facility. The policy also requires that when	Substantial Compliance

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	significant or unexpected adverse drug reactions.	appropriate, ADRs are reported to the Federal Drug Administration through the Medwatch Program when clinically appropriate. The Facility developed a user-friendly form for PCPs, nurses, and DCPs to report ADRs to the pharmacy; usually, DCPs report possible ADRs to nurses. The nurses do an immediate triage and report the findings to the PCP. The pharmacy then does its own review of the ADR. The Monitoring Team reviewed all ADR data that was captured in the pharmacy database on ADRs, from March 2011, through January 2012 and noted that the data elements were effectively captured by the pharmacy department on all ADRs reported. The data was presented in table format and indicated who identified the ADR, type of ADR, suspected medication, and manifestation. A total of 30 ADRs were reported during the ten-month review. Each ADR was accompanied by a comprehensive ADR report, that outlined the findings and provided recommendations. Review of P&TC minutes indicated that all ADRs were appropriately reported to the P&T Committee. The Monitoring Team did not review to ensure that action plans were assessed for efficacy, but will do in subsequent reviews. Review of the last ten ADR reports indicate they were completed timely and appropriately in 10 out of 10 examples (100%). The Pharmacy Director reported to the Monitoring Team that the Facility had developed a comprehensive training venue specific for ADRs and that staff have been trained on the various types of ADRs and how to appropriately report ADRs, which was evident by the quality of completed ADR forms. <u>Summary</u> Because of the high quality of ADR monitoring, tracking, analyzing and reporting, the Monitor Team determined that the Facility is in compliance with Provision N6. Subsequent reviews will include review of training records to ensure that new staff are trained on the reporting practice for ADRs. In addition, the Monitoring Team will also review to ensure that there is appropriate documentation that follow-up action plans were assessed for efficacy. The Monitoring Team compliments the pharmacists, nurses, direct care staff, and physicians who helped develop and implement this process, and who assertively monitor individuals for ADRs.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18	This provision assesses the Facility's ability to identify training needs of staff, and to provide focus case reviews of medications, or classes of medications, that have been identified as having a new risk factor, or potential new risk factor, to individuals who are	Substantial Compliance

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	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.	prescribed, or may be prescribed such medication, at the Facility. The Monitoring Team reviewed the Facility's current policy on DUEs, the 2012 calendar for DUEs, and P&T committee meeting minutes, dated September 21, 2011, and DUE report for Calcium supplements, and flouroquinolones. The Facility maintained a robust process that enables at least one DUE per quarter, which is selected by the P&T Committee. In addition, the DUE Policy requires that DUEs are also provided upon identifying a clinical issue at the Facility that would benefit by a DUE, and whenever there is an FDA or manufacturers warning or advisory about a drug used at the Facility. Importantly, the Facility maintained a process that enabled the pharmacy department to do follow-up of prescribing recommendations, to ensure compliance with the DUE. Review of the DUE calendar for 2012, and 2013, indicated that since January 2012, 7 DUEs were provided through March 2012. Two of the DUEs were scheduled and requested by the P&TC, and five were provided because of manufacturers and FDA advisories. The calendar also indicated that follow-up on DUE recommendations occurred for two of the seven DUEs provided, and was pending for the remaining two DUEs. Review of the DUEs provided for Fluoroquinolones and Calcium Supplements demonstrated that important and clinically relevant information was presented to the clinical staff, that individuals prescribed the medications were reviewed and meaningful recommendations were provided to the prescribing physicians, and that the pharmacy department followed up on it recommendations to ensure that medications recommendations were followed by the prescribing physician. <u>Summary</u> The Pharmacy Department maintains a robust Drug Utilization Evaluation (DUE) process that is supported by policy, and demonstrated by the Monitoring Teams review of completed DUEs. For these reasons, the Monitoring Team determined that the Facility is in 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	Provision N.8, calls for the Facility to maintain an effective process to monitor, assess, report and rectify medication variances. The Monitoring Team reviewed the Facility's medication variance process through discussion with the pharmacy director, review of the medication variance policy, and medication variance committee minutes, reports, summaries, and data on medication variances, from October 2011, through January 2012. The Monitoring Team also reviewed the Facility's procedure for the Medication Variance Committee.	Noncompliance

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	potential medication variances.	Review of Medication Committee Variance Procedure The Medication Variance Committee procedure requires participation by nursing, pharmacy, and physician services. Review of committee meeting minutes reflected that only nursing, and pharmacy staff participated at the committee. Review of physician provider meeting minutes, from October 2011, through January 2012, demonstrated that physicians were provided medication variance data specific for prescribing errors, by the committee; however, despite even when the data reflected a marked increase in errors (78 errors in October; 54 errors in November; 38 errors in December; and 85 errors in January), the January 26 provider meeting minutes stated that the provider had no comment or suggestions on corrective actions. Review of Medication Administration/Variance Committee Policy The Medication Administration/Variance Committee Policy is a robust policy that requires full participation by nursing, pharmacy, and physician services. It requires that there is appropriate monitoring, tracking, reporting, and remediation of medication errors. The pharmacy director chairs the Medication Administration Variance committee. Review of Medication Variance Reporting Forms Completed Medication variance reporting forms were reviewed for November 2011. The forms were comprehensive, and completed appropriately. Medication variance reporting forms were completed by nursing, and pharmacy staff; however, no forms were completed by physician services. Review of Medication Data Elements The pharmacy department collected and analyzed all potential and actual medication errors that occurred during the reporting period. Data fields were divided into prescribing, dispensing, administration, and storage type errors, and were ranked by level of severity. Errors could be tracked for location, type of error, severity of error, prescriber, nurse and pharmacists, as well as by the individual, and specific location that the error occurred. Data was represented in both table and graphic form. The quality of the nursing and pharmacy's management of medication variance data was noted to be effective. Review of Medication Administration/Variance Committee Meeting Minutes Minutes from the Medication Administration/Variance Committee were reviewed for October 2011 through January 2012. The minutes were comprehensive and reflected an excellent summary of all medication errors. The minutes also reflected a comprehensive review of medication variances and, when necessary, action steps to help mitigate future	

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		medication variance. Specific remediation for specific medication errors was to be completed at the department level, in collaboration with administration. Remediation efforts were noted by the Monitoring Team and determined to be appropriate. It was evident, that despite an extremely robust medication variance process, the process was limited by the lack of assertive involvement by physician services. SUMMARY The Facility had developed, and partially implemented, a robust, high quality medication variance process, that is to include full participation by the pharmacy, physician, and nursing departments. Despite meaningful participation by nursing and pharmacy staff, physician services did not participate at the medication variance committee meetings, did not assertively address medication variances through its own physician provider committee, and did not provide the medication variance committee with suggestions on how to remedy prescriber variances. For these reasons, the Monitoring Team determined that the Facility remains not in compliance with Provision N.8. Compliance will require assertive participation by physician service in the medication variance process.	

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

1. For the QDRR process (Provisions N.2 and N.3):
    a. QDRRs must rely on clinical data, such as laboratory studies, body weight, vitals, and abdominal girth, from the same quarter in which the QDRR is being performed.
    b. A comprehensive assessment for metabolic syndrome must be completed for each QDRR, for those individual who are prescribed neuroleptics, and others who are determined to be at risk for metabolic syndrome
    c. The pharmacists must assess and document pharmacotherapy effectiveness and possible side effects.
    d. Ensure that medications are being used appropriately for dose and indication.
    e. Ensure that the use of polypharmacy, benzodiazepines, anticholinergics, and STAT psychotropic medication use is clearly delineated on the QDRR, and that the pharmacists provide review and recommendations for such use.
2. The Facility must immediately enhance its monitoring of metabolic syndrome by ensuring, at a minimum, that a comprehensive review for risk factors of metabolic syndrome be assessed each quarter, and more frequently if clinically indicated (Provision N3)
3. The Facility should review its schedules for monitoring individuals for metabolic syndrome. (Provision N3)
4. Physician Staff must appropriately document an action plan to address all pharmacy recommendations. (Provisions N1, N2 and N4)
5. Physician services must fully participate in the Facility's medication variance process, by assertively addressing prescribing variances, and participating in the committee structure for medication variances. (Provision N8)

The following are offered as additional suggestions to the Facility:

1. Ensure that pharmacists continue to sign off on all scripts to indicate that they are following procedure for medication dispensing
2. Make sure that if a STAT psychotropic medication is used, that a trends analysis, and summary is provided when reviewing data elements for STAT psychotropic medication use, and that the Face-to-Face documentation is completed for both the psychiatrist and the pharmacists. The Face-to-

Face document must include a comprehensive review of the need for the STAT medication, the appropriateness of the specific medication used, if the regularly prescribed psychotropic medication should be changed, and other clinical recommendations. As no STAT psychotropic medications were provided, the Monitoring Team had no opportunities to review this.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. DSSLC Self Assessment and Action Plans (3/16/2012 and 3/8/12) 2. DADS Policy 006.1 At Risk Individuals (2/18/11) 3. DSSLC Policy CMGMT -14 At Risk Individuals 1/1/11 4. Presentation Book for Section I and Section O 5. DSSLC PNM Policy (Draft) 012.2 / CMGMT-32 3/23/12 6. Record reviews: 7. Sample 1: Individuals #175, #235, #373, #396, #461, #464, #478, #520, #576, #672, #741 and #752 8. Sample 2: Individuals #13, #42, #117, #119, #134, #235, #255, #298, #394, #519, and #534 9. Sample 3: Individuals #355, #476 and #679 10. Sample 4: Individuals #30, #62, #147, #211, #220, #715, #739, #743 and #769 11. PNMP for Individual #170 12. A list of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management team (PNMT) members, including credentials 13. A list of continuing education sessions or activities participated in by PNMT members since last review (9/2011) 14. Minutes, including documentation of attendance, for the PNMT and Physical and Nutritional Management Committee (PNMC) meetings for the past 6 months 15. Individual PNMT reports as available for individuals reviewed above 16. Tools used to screen and identify individuals' PNM health risk level 17. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order 18. A list of PNM assessments and updates completed in the last two (2) quarters 19. ISPs for the sample individuals 20. Completed Physical Nutritional Management Plans (PNMPs) for all sample individuals 21. Tools used to monitor implementation of PNM procedures and plans 22. A list of individuals for whom PNM monitoring tools were completed in the last quarter 23. Tools utilized for validation of PNM monitoring 24. 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 25. PNMP template and any instructions for use of template 26. PNM spreadsheets generated by the Facility 27. 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 28. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation since the last review 29. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials 30. Tools and checklists used to provide competency-based training addressing: a. Foundational skills in PNM; and b. Individual PNM and Dining Plans 31. Since the last review, a list of competency-based training sessions addressing foundational skills in PNM **People Interviewed:** 32. Donna Groves OTR Director of Habilitation Therapies 33. Staci Kraus RN-PNMT RN 34. Paula Horn PT 35. Cecilia Payne PNMP Coordinator 36. Erin O'Toole SLP 37. Diane Hierholzer OTR 38. Ten DCPs (Houston Park, Cedar Falls, Eastfield, and Garden Ridge) **Meeting Attended/Observations:** 39. Physical and Nutritional Management Team 4/2/12 40. Physical and Nutritional Management Committee 4/5/12 41. Mealtime Mentors Meeting 4/5/12 42. Mealtimes and Transitions- Houston Park, Cedar Falls, Garden Ridge, and Eastfield
	Facility Self-Assessment: DSSLC's Self-Assessment, updated 3/16/2012, provided comments/status for Sections O.1 through O.8 of the Settlement Agreement. The Facility indicated it was not in compliance with Provisions O.1, through O.8. This was consistent with the Monitoring Team's findings as all provisions were found to be noncompliant. For the self-assessment, the Facility described, for each provision item, the activities the Facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an

	excellent improvement in the Facility self-assessment process. Overall, the Self Assessment and Action Plans included relevant steps that would assist in gaining compliance; however, the activities at times were not consistently in line with what the Monitoring Team assesses as indicated in this report. . Examples of this occurring included: ▪ The Facility's Self-Assessment did not define how the samples were selected. ▪ Not all requirements of the Settlement Agreement had been reviewed. More specifically, within a sub-section, the Settlement Agreement might have numerous requirements, but only some were included in the Facility's Self-Assessment (e.g., Provision O.1 did not include information regarding review by the IDT and Provision O.2 which did not include information regarding identification of PNM risk). If the Facility was choosing, for example, to prioritize assessing certain areas before others, that would be acceptable, but it should be stated specifically. ▪ Results of the "Self Assessment" activities were inconsistently provided due to lack of data systems or processes. Examples are included in Provisions O.2, O.3, O.4, O.6, O.7, and O.8. Overall, the Facility had demonstrated some good use of the data it had collected. Efforts to ensure the validity and reliability of the data will be important next steps, as will using the data to identify areas in which focused attention is needed.
	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 IDT. The PNMC focused more on systems issues. A process that outlines the responsibilities of both teams as well as their scope was developed. There was evidence that data were collected and the team was reviewing this data to better identify system issues. 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 IDT as well. The PNMC meeting attended included review of systems issues in an effort to have a positive impact on care at a facility level. An improvement noted was that the makeup of the PNMT was now in compliance with standards set forth by the Settlement Agreement as DSSLC had added a full time dedicated PNMT Speech Pathologist. Since the last compliance review, DSSLC had developed a localized PNMT policy that defined the roles and responsibilities of the PNMT and the collaboration that was intended to occur with the IDT. A defined criterion that stated what incidents must be referred to the PNMT and what may be referred to the PNMT was included in the policy. Lacking from the policy was the criterion that guided the PNMT in establishing level of PNMT support. 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 IDT or reviewed consistently by the IDT. For examples, please refer to Provision O.3. **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 IDTs 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. 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. During the previous compliance visit, 8% of the individuals were assessed by the PNMT or IDT. This review indicated an improvement of 84% in this specific area. **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. Additionally, training was not consistently provided on an annual basis in areas that are essential to PNM. **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, at the time of the review, the process had not been fully implemented. **Provision O.7:** This provision was determined to be not in compliance. 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 rote manner to continue a strategy with no clear review to measure or evaluate the actual efficacy of the plan. **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 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 were not implemented or identified consistently. Many positives were noted within this provision. DSSLC had taken steps forward with regards to the PNMC and PNMT. It was evident that both of these groups provided a much-needed service to the area of PNM. The primary issue remained that standard assessments continued to lack the comprehensiveness needed to mitigate the risk associated with PNM. Many times, the assessments were only comprehensive when conducted by the PNM and in response to an illness. It is essential that routine assessments do a better job in identifying root causes of incidents and the development of proactive plans of care. Other positives included: • Development of a formal monitoring process that is based upon level of risk • Improved participation by the IDT in response to hospitalizations. • Assignment of a PNM-devoted SLP. Overall, there has been a positive movement on the areas of Section O in which the focus lies on the presence of a committee or the development of a policy or process, The primary concerns that remain focuses more of observing all of these policies being implemented at the level of care. This remains an area that was pervasively lacking.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan	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 IDT. 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), Nurse Operations Officer, Facility Director, and Nurse Case Manager Supervisor. Members of the PNMC included: • Stephen Kubala MD-Medical Director • Donna Groves OTR-Director of Habilitation Therapy • Delia Schilder RN-Chief Nurse Executive • Dora Tillis-Assistant Director of Program Services (ADOP) • Nancy Condon-Facility Director • Sherri Courtney Nurse Operations Officer • Sibylle Graviett Nurse Case Manager Supervisor • Diane Hierholzer, PNMT Occupational Therapist Other members attended as requested or for special clinical specialty as needed,	Noncompliance

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	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.	including the QA Director, Residential Services Director, Behavioral Services Director, Dental Director, Pharmacy Director, Psychiatrist, Infection Control Nurse, Skin Integrity Nurse, Diabetes Educator, PNMT Nurse, PNMT Physical Therapist, and PNMT Speech Language Pathologist. Per review of the PNMC minutes from 11/3/11 to 3/22/12, there was evidence that the PNMC reviewed systemic issues at DSSLC. Among the issues discussed included: • Occurrence of pneumonias • Methods to improve training • Development of processes related to PNM • PNM clinical indicators • Hospital Return Process PNMC attendance was lacking as some members either did not participate at all or were present in a very limited manner. An examples of lack of attendance included: • Medical Director attended 10 of 15 meetings (67%) Attendance by all members is needed in order to comprehensively address the systemic issues identified by DSSLC. The PNMC in collaboration with the QA department were in the process of developing clinical indicators that would assist DSSLC in establishing facility systemic trends. Among the clinical indicators were hospitalizations, ER visits, Deaths, Skin Integrity, Risk Ratings, Enteral Nutrition, Aspiration Pneumonia, Suction Tooth Brushing, Dental, Choking Incidents, Fractures, Falls and Change in Mobility Status. The ability to pull these reports moving forward will allow DSSC to be more proactive in identifying issues and developing strategies to address the issues in a more proactive manner. The PNMC also developed a form titled "Action Plan Considerations" which was intended to assist the IDT in better being able to identify potential tests and assessments that may aid in the mitigation of risk associated with several PNM concerns including choking, aspiration, respiratory compromise, weight, constipation, GI problems, skin integrity, falls, fractures, and dental. The Physical and Nutritional Management Team (PNMT), which focused on clinical issues, consisted of: • Dr Stephen Kubala MD-Medical Director • Donna Groves OTR-Director of Habilitation Therapy • Staci Kraus-RN-PNMT RN • Mary Kuhfeldt RD	

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		• Paula Horn PT • Cecilia Payne PNMP Coordinator • Erin O'Toole SLP • Diane Hierholzer OTR PNM Team attendance records from 9/12/11 to 2/29/12 documented consistent attendance by PNM Team standing members. An improvement noted was that the makeup of the PNMT was now in compliance with standards set forth by the Settlement Agreement as DSSLC had added a full time dedicated PNMT Speech Pathologist. Another improvement noted was that PNMT minutes were now gathered that provided clearer evidence of discussion. Reports and actions plans continued to supplement the meeting minutes and provide more detailed information regarding staff assignments and timelines. Review of documentation of PNM clinical instruction submitted by the Facility revealed opportunities for PNMT members to participate in trainings relevant to increasing their knowledge of PNM. The courses offered focused on: • Issues in Evaluation and Treatment of Individuals with Developmental • Disabilities - Integration of Clinical Services plus PNMT Training • Breathing, Digestion and swallowing: Best practices in Dysphagia • Management • Dementia Outside the Box Other conferences attended by members of the PNMT included: • Understanding Anemia • Pharmacology for Rehab PNMT meetings were held a minimum of weekly with many times occurring twice weekly. Per review of meeting minutes, there were 24 meetings that occurred between 9-12-11 and 2/29/12. Since the last compliance review, DSSLC had developed a draft localized version (CMGMT-32) of the DADS PNM policy (012.2) that defined the roles and responsibilities of the PNMT and the collaboration that was intended to occur with the IDT. A defined criterion that stated what incidents must be referred to the PNMT and what may be referred to the PNMT was included in the policy. Lacking from the policy was the	

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		criterion that guided the PNMT in establishing level of PNMT support. Although the PNMT review holds promise of improving clinical services to individuals, it must demonstrate both careful review and assertive action. One example in which this did not yet occur was Individual #170. The PNMT noted that the individual experienced two episodes of aspiration pneumonia within a one-month period, the only comment by PNMT was "recommend the level of assistance and follow-up in six weeks." 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 IDT or reviewed consistently by the IDT. 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 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 #1 consisted of 13 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 sample was chosen by choosing every tenth name on the aspiration list and every fifth name on the choking at risk list. Individuals for sample #2 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 three individuals who accounted for 50% of the individuals who experienced a choking event and eight individuals who accounted for 100% of the individuals who experienced an aspiration event. The choking portion of the sample was gathered by choosing every other name on the DSSLC list. Sample #3 consisted of three individuals who accounted for 100% of new admissions since the previous compliance review. Based on a review of 27 individuals' (sample #1, #2 and #3) most recent OT/PT assessments, three of 27 Individuals (11%) were provided with a comprehensive assessment by the PNM team and/or IDT that focused on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, and 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 #461's OT/PT assessment stated the individual demonstrates reduced oral prep phase but did not provide information regarding the functional relevance of the issue.	Noncompliance

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		While the function of interventions was included in the assessments, 12 of 27 (44%) (Sample #1, #2, and #3) assessments reviewed contained clear investigation as to why interventions (e.g., adaptive equipment, bed elevation) were appropriate. For example: • Individuals #235 and #672 were 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. A comprehensive PNMT evaluation was completed by the PNMT as based on referral by the IDT. Components of this assessment included: • Potential for aspiration, choking, and pneumonia • Need for specialized positioning • Causes of significant unplanned weight loss or gain • Reasons for significant alteration of diet texture • GI problems • Risks for and causes of falls • Circulatory issues • Skin integrity • Assistive equipment • Therapeutic positioning • Positioning for eating, medication administration and oral care • Position for enteral intake • Mobility issues • Other therapeutic interventions As of this review only two had been completed and one was still in the progress of being developed in the revised PNMT format. Due to the lack of a sufficient sample, the PNMT evaluation will be assessed at a later review. The above components represent the potential for a comprehensive assessment but much of this determination will be based on how well each of the identified components are assessed. Based on a review of 11 (samples #2) records of Individuals who experienced an aspiration or choking event, 5 of 11 (45%) 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 #42 and #119 were identified as being at a “medium risk” of aspiration but per guidelines should have been listed as a “high risk” due to	

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		recent aspiration events. • Individuals #255 and #534 were identified as being at a "medium risk" of choking but per guidelines should have been listed as a "high risk" due to recent choking events. The IDT had the ability to lower the risk; however, there was no evidence of the rationale behind the lower risk score. Twelve of 13 (92%) individuals who were diagnosed and/or hospitalized with a PNM issue (sample #2) were assessed by the PNMT or IDT. For example: • Individual #534 had a choking event on 9/2/11. On 8-16-11, the COTA and OT conducted observations and provided recommendations to mitigate risk. A swallow study was also ordered to provide a more formal assessment of the swallow structure and functioning. • Individual #519 was diagnosed with aspiration pneumonia on 11/9/11. There was evidence of the IDT and PNMT meeting to discuss the event and focus on potential indicators or triggers that led to the aspiration event. As a result of the meeting, the individual's positioning plan was revised. During the previous compliance visit, 8% of the individuals were assessed by the PNMT or IDT. This represented an improvement of 84% in this specific area. Individuals who had returned from the hospital with a PNM related diagnosis were reviewed by the PNMT. The level of oversight by the PNMT was divided into four categories (Full Assistance, Consultation, Monitor for change, and Watchful Eye). While the levels identified the role of the PNMT in each level, there was not a defined criterion that guided the PNMT in determining who belonged in what level. Lack of criteria decreased the likelihood that individuals would receive a comprehensive PNM evaluation. For example: Individual #134 had multiple pneumonias over the past quarter but was listed as a level 3 which means that the PNMT would not need to look at the individual for 6 months. The PNMT Nurse was also responsible for assessing each individual who returned from the hospital with a PNM related issue. The concern noted by the Monitoring Team was that there was not a clear connection between the PNMT Nurse assessment and how it guides in the level of oversight provided by PNMT. In its current format, the assessment consists of basically a SOAP note that focuses on current vital signs and status but does not aid in detecting the need for PNM assessment by asking specific questions regarding change in PNM status.	

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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 only contained vague and general information regarding oral care, medication administration and head of bed elevation. Based on a review of 27 individual PNMPs (sample #1, #2, and #3), individuals were not provided with a comprehensive PNMP. • In zero of 27 PNMPs reviewed (0%), comprehensive strategies for oral hygiene were included. • Four of 27 PNMPs (14%) 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 27 PNMPs reviewed (0%), PNM triggers to be observed and reported were listed as part of the plan. Per the Habilitation Director, the newly formatted PNMPs should begin to address this concern. Due to the format being relatively new, this area will need further review at the next compliance visit. • In 14 of 27 PNMPs (51%) reviewed, comprehensive strategies for medication administration were included. Review of the new format suggests the triggers that would be included on the PNMPs would consist of actions that may increase the risk of an undesired event such as aspiration or falls; however there was no connection between the trigger sheets and the triggers that would be contained on the PNMP. The triggers on the PNMP should match those on the Aspiration Triggers sheets since these triggers were supposed to indicate increased risk of undesired event (I.e., aspiration) 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. Oral Care and Medication Administration were included in the PNMP but, as noted above, most were not comprehensive as they lacked detail regarding number of pills that can be safely tolerated at one time, adaptive equipment, and strategies on how to assist during oral care. Additionally, adaptive cups that were necessary for safe intake during dining were not included as part of safe intake during medication administration. Per interview with the Habilitation Director, new formats of the PNMP had been developed and this issue should begin to be addressed. This area will be reviewed again at the next compliance visit.	Noncompliance

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		There were, however, several positive practices that the Facility should ensure continue. • In 27 of 27 PNMPs (100%) reviewed, positioning instructions for wheelchair and alternate positions instructions were included as applicable. • In 27 of 27 PNMPs (100%) reviewed, transfer instructions were included as applicable. • In 27 of 27 PNMPs (100%) reviewed, the mealtime/dining plan included intake information for mealtime and snacks • In 27 of 27 PNMPs (100%) reviewed, the mealtime/dining plan included food/fluid textures as applicable. • In 27 of 27 PNMPs (100%) reviewed, the mealtime/dining plan included behavioral concerns related to intake. • In 27 of 27 PNMPs (100%) reviewed, individual adaptive equipment for mealtime was included. • In 27 of 27 PNMPs (100%) reviewed bathing/showering positioning and instructions were included Based on a review of an identified sample of 27 individual records (Samples #1, #2, and #3) PNMPs and dining plans were not formally developed with input from the IDT. In zero of 27 records reviewed (0%), PNMPs were clearly developed with input from the IDT with an emphasis on DCPs, medical/nursing staff, and behavioral staff (if appropriate). Per record review, there was evidence in the ISPs that the PNMPs were included, but there was no evidence of discussion or input from other team members. PNMPS were reviewed by the IDT and consistently updated in a timely manner by Habilitation Therapies as indicated by a change in the person's status. In 11 of 11 records reviewed (100%) (Sample #2), PNMPs were revised in a timely manner as indicated by a change in the individual's status (such as hospitalization, or change in diet texture). This represented an increase of 80% in this area.	
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,	The therapy clinicians generally developed PNMPs and Dining Plans with limited input by other IDT members as described above. Per review of the ISPs, there was no evidence of discussion of the PNMP and how it was positively or negatively impacting the person's life. PNMPs were located in the individual notebooks that followed the individuals that lived on Houston Park and Cedar Falls. Additionally, PNMPs were located at the Dental office, Life Skills, Vocational Rehabilitation, infirmary, MARs, and in the clinical record. Although, the PNMPs were provided at various locations, at no time during any of the observations was staff observed referring to the PNMPs.	Noncompliance

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	and other activities that are likely to provoke swallowing difficulties.	Staff did not consistently implement interventions and recommendations outlined in the PNMP and/or Dining Plan. 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 eight of 25 (32%) observations, staff were following mealtime plans. • In five of 15 (33%) 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 #398 was not provided with cues to take small bites and sips, or swallow between bites thus increasing the risk of choking • Individual #171 was eating at an unsafe rate with no cues to slow down. • Individual #2 was observed incorrectly using a nosey cup. • General safe mealtime practices such as providing liquids during the meal and encouragement to eat at a slow pace were also not observed. Overall, there was little improvement since the last compliance visit with regards to ensuring individuals participated safely in mealtime activities. 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 #441 was observed in supine position when the plan called for him to be in right side lying. • Individual #66 was still in bed when the plan called for him to be in his wheelchair. • Individual #218 was observed slid down in bed when the plan called for him to be elevated. • Individual #485 was observed in wheelchair with no footrest and chair tilted back resulting in her feet dangling thus preventing her from being able to self propel. • Individual #83 was observed tilted back in the wheelchair receiving enteral feeding when the plan called for her to be tilted all the way forward to prevent reflux. 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	

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		implementation. Based on interviews with ten DCPs, responses to questions about PNMPs were: • Where is the PNMP/Dining Plan located? (100% answered correctly) • What kind of transfer do they require? (100%) • What do you look for to ensure the individual is in the correct position? (10%) • Why does the individual need thickened liquids? (40%) • Why does individual eat modified texture foods? (50%) • Why does the individual require a specific utensil? (40%) • Why does the individual require a specific assistance technique? (0%) • What are the individual's risk indicators? What do you look for before, during and after the meal? (40%) • Does the individual have an Aspiration Trigger Data Sheet, where is it kept and when do you document? (60%) • Have you been trained to implement this plan? (80%) • Who do you contact if you have difficulty with the plan or the equipment? (90%) This lack of knowledge results in individuals being placed at an increased risk due to lack of staff understanding of the rationale for implementing strategies listed in the physical and nutritional management plans 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 again little improvement in staff knowledge regarding specific plans or the implementation of these plans.	
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: • Risk Guidelines • Aspiration Pneumonia • PNMP philosophy • Techniques and equipment for individuals served • Lifting and Transfer • Positioning • Dining/eating/oral intake • Communication • Monitoring Procedures	Noncompliance

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		DSSLC conducted a PNM training fair that focused on the areas listed above. The fair resulted in over 500 staff receiving new and additional trainings related to the above areas. Concerns were that this is an area that would benefit nursing as well and there was a need to expand training to all nurses, and the lack of implementation despite staff receiving the new training just weeks prior to the compliance review.. The hope of DSSLC is that the new monitoring process that is just starting to be implemented will improve the issues with implementation. Per PNM policy, training will be provided at least annually and as indicated by monitoring. At the time of the review, the only trainings provided annually included Lifting/Transfers and CPR. Missing from the annual trainings were Mealtime, Positioning, and Foundations of PNM. The PNM Policy also stated that PNMPs will be trained upon development as determined by plan revisions. Per review of training required for PNMP revisions (Sample#2); trainings occurred in response to revisions five of five (100%) opportunities. 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. The PNMC was working on a process to address this concern but at the time of the review a process had not been implemented.	
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.	Since the last compliance review, a policy/protocol that addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted was developed as part of the overall PNM policy at DSSLC. 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: • 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 a 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	Noncompliance

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		the percentage of monitors completed in each identified PNM area (dining, oral care, etc), as well as data aggregated by areas addressed by the PNM monitoring form. DSSLC was also in the process of developing and implementing a universal monitoring system that will allow the PNMC and QA to pull reports to ensure that all areas (oral care, medication administration etc...) are provided with balanced monitoring. This system was in the process of being developed and therefore will need to be reviewed at the next compliance review. Per review of the monitoring list, only 21 (0.15%) of the approximately 1394 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 order to obtain this information, the Monitoring Team had to hand count the number of completed monitors as well as the type of monitor completed to gain an understanding of whether monitors were conducted in all areas of need. There was a newly developed process in place that ensured individuals with increased PNM issues were provided with increased monitoring. This process was included in the PNM policy and directed clinical staff to conduct effectiveness monitoring for all high-risk individuals at a minimum of twice monthly in various activities. Individuals at medium risk would be provided with monitoring once per quarter and those who were low risk annually. Again, this process was newly implemented; therefore, more review will be needed in subsequent visits. In addition to the standard effectiveness monitoring schedule, monitoring was provided in two ways: • The risk process included a monitoring component where the IDT and/or PNMT determined through an action plan specific areas of needed monitoring. This type of monitoring was more specific to an issue at hand (i.e., bed positioning) • General monitoring that focused on mealtime standards were provided by non-clinical staff. While the above monitoring processes should assist DSSLC in better monitoring individuals, there was not an elevated level of review regarding the effectiveness of interventions and supports in the annual assessments. The assessments lacked consistent information regarding how well the PNMP performed in mitigating risk and if the plan and its strategies had a positive impact on the individual's quality of life. This should be a key function of the professional staff clinicians. DSSLC was lacking a consistent method to ensure inter-rater reliability. Monitors were	

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		not provided reliability checks on an annual basis by therapists to ensure format remains appropriate and completion of the forms are correct and consistent among various individuals conducting the monitoring.	
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 27 individual records (Sample #1, #2, and #3), the PNM Team or IDT 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 ISP, 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). 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 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 had an aspiration event 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: • 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."	Noncompliance
O8	Commencing within six months of the Effective Date hereof and with	The following section was based on a sample gathered from individuals who received enteral nutrition (Sample 4). Nine of these individuals were included in the sample	Noncompliance

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	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.	reviewed by the Monitoring Team. The sample was chosen by selection of every 10th individual included on the enteral nutrition list provided by DSSLC. The sample accounted for approximately 10% of those receiving alternate means of nutrition. There were 90 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 IDT Based on the sample of nine individuals (sample 4), nine of nine (100%) individuals had received the interdisciplinary enteral nutrition assessment provided by the State. Out of the nine aspiration/enteral evaluations noted in the records, one of nine evaluations (11%) was fully completed but there was still lack of assessment in statement or recommendations. Issues missing from the evaluations included action plans, pharmacy review, and pathways to oral intake. All nine individuals had received an OT/PT 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 or MBSS 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. Based on a review of nine individuals' ISPs, for zero of nine (0 %) (Sample #4) who	

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		received enteral nutrition, the individual's ISP clearly documented the rationale for the continued need for enteral nutrition. An example of an individual ISP that did not document the rationale for the continued need for enteral nutrition was that Individual # 220's ISP simply stated that nutrition is provided enterally. Nine of nine 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. Per the Habilitation Director, DSSLC was investigating the possibility of having training provided that focused on potential pathways to oral intake. This would be a positive step in ensuring individuals are provided with the east restrictive diet as well as guide them to better overall oral management.	

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

1. Integrate into the PNMC process a method for data analyses and review (Provision O.1)
2. 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. (Provision O.3)
3. Adaptive mealtime equipment that is determined to be needed during mealtime should be carried over to medication administration as well. (Provision O.3)
4. 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.8).
5. All individuals who are determined to be at an increased risk should only be provided assistance from staff who have received competency based training specific to that individual (Provision 0.7)
6. 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).
7. All nursing staff would benefit from attending the dysphagia training provided by central office. This training would improve the knowledge base needed to assist in proactively providing care with regards to PNM. (Provision O.5).
8. Aspiration Trigger Data Sheet should be modified to include triggers specific to the individual (Provision O.7).
9. 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. A requirement that all monitoring forms provide instructions for individual monitoring indicators to support consistency in monitoring and inter-rater reliability;
    b. Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;
    c. Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues;
    d. Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and

e. Establishment of thresholds for staff re-training. (Provision O.7)

10. 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)
11. Triggers listed on the PNMP should have a correlation with the triggers listed on the aspiration trigger data sheet allowing tracking and the potential of referral should they occur. (Provision O.3)
12. QDDPs should review the aspiration trigger data sheets and include analysis regarding whether the plan is effective in mitigating risk as part of the monthly summary (Provision O.7)

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

1. 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, able 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 Self Assessment and Action Plans 3/16/12 and 3/8/12 43. DADS PNM Policy 012.2 / DSSLC PNM Policy CMGMT-32 3/23/12 2. Record Reviews: • Habilitation Sample 1: Individuals #175, #235, #373, #396, #461, #464, #478, #520, #576, #672, #741 and #752 • Habilitation Sample 2: Individuals #13, #42, #117, #119, #134, #235, #255, #298, #394, #519, and #534 • Habilitation Sample 3: Individuals #355, #476 and #679 • Habilitation Sample #5: Individuals #94, #153, #172, #204, #209, #578, #580 #669, #740 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 Therapies 2. Staci Kraus-RN-PNMT RN 3. Paula Horn PT 4. Cecilia Payne PNMP Coordinator 5. Diane Hierholzer OTR 6. Ten DCPs (Houston Park, Cedar Falls, Eastfield, and Garden Ridge) **Meeting Attended/Observations:** 1. Physical and Nutritional Management Team 4/2/12 2. Physical and Nutritional Management Committee 4/5/12 3. Mealtime Mentors Meeting 4/5/12 4. Mealtimes and Transitions- Houston Park, Cedar Falls, Garden Ridge, and Eastfield

	Facility Self-Assessment: DSSLC's Self-Assessment, updated 3/16/2012, provided comments/status for Sections P.1 through P.4 of the Settlement Agreement. The Facility indicated it was not in compliance with Provisions P.1 through P.4. This was consistent with the Monitoring Team's findings as all provisions were found to be noncompliant. For the self-assessment, the Facility described, for each provision item, the activities engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. Overall, the Self Assessment and Action Plans included relevant steps that would assist in the state in gaining compliance; however, the activities at times were not consistently in line with what the Monitoring Team assesses, as indicated in this report. Examples of this occurring included: ▪ The Facility's Self-Assessment did not define how the samples were selected. ▪ Not all requirements of the Settlement Agreement had been reviewed. More specifically, within a sub-section, the Settlement Agreement might have numerous requirements, but only some were included in the Facility's Self-Assessment. For example, Provision P.1 did not include information regarding the need for assessment in the event of a change in status. This information was contained within the action plan and therefore should be reflected in the self assessment section as well. If the Facility was choosing, for example, to prioritize assessing certain areas before others, that would be acceptable, but it should be stated specifically. ▪ Results of the "Self Assessment" activities were inconsistently provided due to lack of data systems or processes to review the results of the "Activities engaged in." An example is included in Provision P.1. Overall, the Facility had demonstrated some good use of the data it had collected. Efforts to ensure the validity and reliability of the data will be important next steps, as will using the data to identify areas in which focused attention is needed.
	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. 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. **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. Restorative programs were not readily utilized to minimize regression of skills. **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 Occupational Therapy/Physical Therapy (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. A positive note was that DSSLC had installed various bathing options and were in the process of ordering more options for individuals. (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: • The Facility provided an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience. • 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. • Based on reviews of PNMPs for 27 individuals (sample #1, #2, and #3), equipment was specified for 27 of 27 (100%) plans reviewed. As with Section O, the policy component of Section P showed improvement but DSSLC continued to lack in the areas that focused on assessment and/or the implementation of strategies intended to mitigate risk and/or enhance skills.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational	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), and five Physical Therapists (PT). There are openings for one OT	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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. OT and PT completed annual assessments/updates 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. Sample #5 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 #3) (new admissions) had received an OT/PT assessment. Assessments indicated whether or not the individual required OT/PT supports and services for 27 of 27 (100%) (Sample #1, #2, #3) records reviewed. The OT/PT assessment addressed general aspects of 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. • There was no comparative analysis of health and functional status from the previous year. In the cases in which therapy supports had been provided, there	

#	Provision	Assessment of Status	Compliance
		was no assessment as to the effectiveness of the interventions as evidenced by lack of identification of clinical indicators. • 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. A new format was in draft status for OT/PT evaluations. Based upon review of the assessment, the format and guidelines appeared to direct staff in providing a comprehensive assessment. Whether or not the revised assessment (3/23/12) will result in more comprehensive assessments will need to be reviewed at the next compliance review. Five of the 27 (18%) assessments (Sample #1, #2, and #3) 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 contain appropriate rationale included: • Individuals #153 and #740'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 27 OT/PT assessments (Samples #1, #2, and #3), 100% included signatures and date of both OT and PT. Based on review of 10 individuals with changes in status (sample #5), two of ten (20%) received an assessment or review as indicated by a change in the individual's status or as dictated by monitoring results for: • Individual #740 had 15 falls that occurred since the last compliance review without evidence of reassessment or team discussion • Individual #153 had 12 falls that occurred since the last compliance review without evidence of reassessment or team discussion When there was team discussion, the discussion did not contain root cause analysis of the event that caused or signaled a change in status..	
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	Based on review of comprehensive OT/PT assessments or updates, PNMPs and associated instructional plans, Activity Plans, Treatment plans and clinician progress notes for 27 individuals (sample #1, #2, and #3) receiving OT/PT services, plans were developed within 30 days of the date of the assessment/update as indicated by the assessment.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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. A positive note was that DSSLC had implemented new bathing systems (Sure Hands Shower Bath and Broda Shower Chair) in an effort to expand options for individuals who require more intensive interventions during this activity. At the time of the review, two more shower chairs were on order in addition to the one that was already available at DSSLC. Access to this equipment has allowed for more individualized bathing options as well as improving the safety of the individuals through better overall positioning. Based on reviews of PNMPs for 27 individuals (sample #1, #2, and #3), equipment was specified for 27 of 27 (100%) plans reviewed. Within 30 days of the annual ISP, or sooner as required for health or safety, a plan was developed as part of the ISP but was not consistently reviewed by the IDT. 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 IDT related to program changes or changes in status. Please refer to Provision P.1 for more information. 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. Findings were often not integrated into the ISP. Recommendations other than the PNMP were often not included and there was no evidence of therapist-designed skill acquisition plans (SAPs) in general or related to direct therapy services. 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.	

#	Provision	Assessment of Status	Compliance
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	A s mentioned in Provision O.5, training curricula revealed training in the following areas: • Risk Guidelines • Aspiration Pneumonia • PNMP philosophy • Techniques and equipment for individuals served • Lifting and Transfer • Positioning • Dining/eating/oral intake • Communication • Monitoring Procedures 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: • What kind of transfer do they require? (100%) • What do you look for to ensure the individual is in the correct position? (10%) • What is the individuals positioning schedule? (40%) • See Provision O.4 for additional information.	Noncompliance
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	A system of monitoring of the PNMPs, and the condition, availability, and effectiveness of physical supports and adaptive equipment was implemented at DSSLC and addressed in Provision O6 above. 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 Provision O5). Since the last compliance review, a policy/protocol that addresses the monitoring process and provides clear direction regarding its implementation and action steps to	Noncompliance

#	Provision	Assessment of Status	Compliance
	nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	take should issues be noted was developed as part of the overall PNM policy CMGMT-32 3/23/12 at DSSLC. 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 #441 was observed in supine position when the plan called for him to be in right side lying. • Individual #66 was still in bed when the plan called for him to be in his wheelchair. • Individual #218 was observed slid down in bed when the plan called for him to be elevated. • Individual #485 was observed in wheelchair with no footrest and chair tilted back resulting in her feet dangling thus preventing her from being able to self propel. • Individual #83 was observed tilted back in the wheelchair receiving enteral feeding when the plan called for her to be tilted all the way forward to prevent reflux. 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: • 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 a lack of data acquisition and analysis regarding the completion of the monitoring forms. As of this review, the PNMC was unable to readily 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. In order to gain this information, the monitoring had to hand count and hand review each completed form. This type of retrieval was not conducive to the review and analysis of data.	

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 ISP skill acquisition programs to provide multiple opportunities for incidental teaching, formally and informally (Provision P.2).
5. Restorative and maintenance programs should be developed by OT/PT to prevent decline in ambulation and overall functioning (Provision P.2).
6. Integrate direct and indirect supports into the ISP through the development of SAPs that include measurable goals with performance criteria.
7. Ensure that there is a clear measure of progress related to the goals and that these and other critical clinical measures, as well as functional health status indicators, are used to justify initiation, continuation, and/or termination of interventions (Provision P2).
8. 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).
9. There is a continued need for improved staff attention to the details of proper positioning and alignment in wheelchairs and dining chairs and compliance with the PNMPs. (Provision P.4)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. DSSLC Self-Assessment 3/16/12 2. DSSLC Action Plan 3/8/12 3. Denton Presentation Book 4. Dental Care – Suction Toothbrushing Protocol DS-04, dated 3/15/12 5. Dental Services Overview, dated 6/30/11 (no State or Facility number) 6. Procedure for Dental Emergencies, dated 8/1/11, DS-16 7. List of Dental Emergencies for October 2011, through March 2012 8. Dental records for Individuals #757, and #87 9. Dental summaries, associated dental notes, and PSP reports for the last 13 individuals who received their annual dental examination as of 4/5/12 and earlier 10. Clinical records for Individuals #461, #66, #205, #737, #139, #520, #710, #244, #3, #362, #787, #247, #289, and #769 **People Interviewed:** 1. Eric Wear DDS, Dental Director 2. Pam Fourrier, Dental Assistant **Meeting Attended/Observations:** 1. Observation of suction toothbrushing, home 503c 2. Observation of oral hygiene outcomes at living area Cedar Falls
	Facility Self-Assessment: The Monitoring Team concurred with the Facility's self-assessment of noncompliance for Provisions Q.1,and Q.2. The Monitoring Team noted that the self-assessment, and plan focused mostly on timeliness of dental services, which the Monitoring Team agrees is important; however, the Facility must also focus on assessing clinical processes, and clinical outcomes, such as ensuring that there is an effective oral hygiene process at the living area, and that individuals experience benefit by reduced plaque, and calculus formation, and less bleeding of their gums. The Facility's self-assessment for Provision Q.2 focuses on completion of activities, such as completing dental summaries, and submitting them to the IDT timely, and if appointments were kept. The Monitoring Team suggests that the Facility also focus on processes such as implementing the dental database, monitoring efficacy of the process to reduce the use of sedation, and development of general QA efforts to assess clinical outcomes.
	Summary of Monitor's Assessment: The Monitoring Team recognizes that the Facility employed a new director of dental services, in March of 2012, and understands that process improvement had been delayed during this staffing transition. Following its meeting with the new director, the Monitoring Team is confident that dental services will continue to be enhanced at the Facility. Since the last review period, the dental department has maintained a robust process to address dental emergencies, incorporated new technology, such as portable x-ray devices, enhanced the reviews of individuals during their annual dental assessments, and is in the process

	of implementing a dental database system. The Monitoring Team compliments the Facility for moving forward, despite the noted changes with staff. Provision Q.1. The Facility maintained an effective mechanisms that ensured the delivery of emergency dental services, and maintained a robust staff of dentists; however, the Monitoring Team has significant concerns over the staffing of dental hygienists and assistants, and recommends that administration review staffing needs to ensure that the quantity of dental hygienists and dental assistants is adequate to support dental service needs. The Monitoring Team noted significant issues with regards to outcomes of oral health care and oral hygiene efforts, including the use of suction toothbrushing, that was provided at the living area, as there was a very high incidence of poor oral hygiene, plaque, gum bleeding, and calculus formation noted following review of dental summaries. For these reasons, the Monitoring Team determined that the Facility remains not in compliance for this provision. Provision Q.2. The Monitoring Team determined that the Facility remains not in compliance with Provision Q.2, because the Facility: • Did not have an effective QA process to assess positive and adverse outcomes of dental services. • Did not implement an effective method to manage dental related to scheduling, missed appointments, and type of services provided and required, and • Did not have a robust process that ensures that dental services are adequately reflected in the personal support team/interdisciplinary team process.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	Provision Q.1, deals with the Facility's ability to provide routine and emergency dental services to individuals supported by the Facility. The Monitoring Team reviewed issues including staffing and administration of the dental office, routine and emergency dental services including oral health care and oral hygiene, integrating dental notes into the integrated progress notes, and timeliness of dental services. <u>Staffing And Administration</u> The Facility gained a new dental director on March 9, 2012. The director's time is divided into 80% administrative and 20% clinical. In addition, the Facility has one full time dentist, who provides care 100% of the time. The Facility maintains contracts with a dental anesthesiologist, who provides i.v. sedation to individuals approximately 5-6 days per month, an oral surgeon who provides oral surgery approximately 2 times per month, and an additional dentist who provides dental service to individuals who benefit from oral sedation, one day per month. At the time of this review, the full time dentist was not certified to perform dental treatments on individuals who receive oral pre-treatment sedation; however, the necessary training to enable this dentist to be certified is being considered for the near future.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The Facility maintained two full-time positions for dental hygienists; however, one of the two remained on leave, allowing for only one hygienist to provide services to individuals. The Facility finds it very difficult to provide the necessary dental hygienic care and training of individuals with only one hygienist available to treat 518 individuals. The Monitoring Team determined that, based on the number of individuals served, and the expectations for the hygienist, which included assisting with the desensitization programs, training staff and monitoring of oral hygiene at the living area, participating at team meetings, providing backup support for the dental technician, and providing dental hygiene, staffing issues must be reviewed by administration, as limited dental hygiene staff is contributing to the continued poor quality of oral hygiene, as determined following review of dental summaries. The Facility had two full-time dental assistants; however, one of these positions is used as for clerical work only. This individual must complete all dental consents, schedules, answer the phone, and liaison with guardians, among many other activities. The second dental assistant provides clinical support to the dentist. The Monitoring Team questions the efficacy of having just one full time dental assistant to assist with clinical care at the Facility, to support two dentists in addition to several contract dentists. Developmental disability dentistry generally requires the support of two dental assistants whenever the dentist or hygienist provides dental services. Dentists and a hygienist cannot operate without adequate dental assistance. The Monitoring Team has concerns over the Facility's ability to provide least restrictive approaches to sedation, when there is limited dental assistance to support care in light of potential behavior and involuntary movement challenges.. During the Monitoring Team's discussion with the dental director, it was observed that all clerical support is provided at a small desk, which is located within the dental lab. The dental office receives numerous phone calls and makes phones regarding the oral health care issues of individuals who reside at the Facility. There is no privacy among individuals who receive services and the dental office clerical support staff who is discussing confidential information over the telephone. Importantly, because of the filing cabinets, and desks, there is only a very limited space to provide clinical service. This challenge to confidentiality should be addressed. <u>Oral Health Care</u> For the last ten individuals seen for their annual dental examination, as of 4/15/12 and prior, the Monitoring Team requested the last two annual summaries, and copies of all dental notes for past six months, and of the past 12 months Individual Support Plans (ISPs) and addendums. The Monitoring Team was provided with a total of 13 dental summaries reviewed.	

#	Provision	Assessment of Status	Compliance
		Of the 13 dental summaries, one (8%) demonstrated good oral hygiene, while three (23%) demonstrated fair oral hygiene, and nine (69%) demonstrated poor oral hygiene. Of the 13 dental summaries, one (8%), was determined to have light calculus formation, while six (46%) demonstrated moderate calculus formation and six (46%) had heavy calculus formation. Of the 13 dental summaries, two (15%) were associated with no bleeding, while seven (54%) were associated with moderate bleeding and four (31%) were associated with heavy bleeding. Of the 13 dental summaries, one (8%), was determined to have stage I plaque and a very low risk for periodontal disease, while three (23%) were determined to have stage II plaque formation, and nine (69%) demonstrated stage III plaque formation and a high risk for periodontal disease. By review of the dental summaries, the Monitoring Team determined that the provision of oral health care at the Facility was less then acceptable. Oral Hygiene Efforts At The Living Area--Suction Toothbrushing: The Facility developed a protocol for oral care for individuals who were enterally fed or high risk for aspiration, and implemented the policy on 6/30/11. The protocol calls for the Facility to provide suction toothbrushing for all individuals who are at risk for aspiration, and who receive enteral nutrition. Although 92 individuals were provided suction toothbrushing, the pharmacy director indicated that not all individuals had been completely assessed, and that further assessment to determine need for suction toothbrushing occurs at the time of the annual dental assessment. Once initially assessed by the dentist, according to the dental director, the nurse is to report to the dental office any individual who experiences a health care issue that requires the use of a suction toothbrush. The current policy on suction toothbrushing is unclear on the monitoring and reporting responsibilities for individuals who need suction toothbrushing. Also, per discussing with nursing staff, nurses were unclear as to this process. The Monitoring Team observed suction toothbrushing at home 512C. Staff was unclear as to the suction toothbrush policy and the individual's support plan for suction toothbrushing. Observation of Individual #467 indicated that suction toothbrushing was administered to this individual for approximately ten seconds, and water was used when applying the suction toothbrush, which is against protocol.	

#	Provision	Assessment of Status	Compliance
		Oral Hygiene Efforts At The Living Area--Regular Toothbrushing and Dental Flossing: The Monitoring Team spent the majority of its time at homes that supported individuals who were severely medically compromised, and did not have an opportunity to observe the oral hygiene care of individuals, other than suction toothbrushing. However, the information about oral status of individual found in the dental summaries and reported above indicates improvement is needed. <u>Routine And Emergency Dental Services</u> Timeliness Of Dental Services: Because of the Facility's limited ability to manage data elements, the Monitoring Team was unable to efficiently obtain an accurate list dental services that were provided. The Facility is implementing a dental database system that will enable accurate assessment of when dental services were, and will be provided. Dental Emergencies: The Monitoring Team was informed by the dental director of the Facility's emergency dental procedure, and that in the event of a dental emergency that occurs after hours, the on-call physician would initially triage the dental issue, and if necessary, contact the on-call dentist or hygienist, who would then triage the dental emergency. For more serious cases, the nurse and/or on-call physician would immediately triage the individual to the emergency department. Review of the documented entitled Dental Services Overview, dated 6/30/11, did not adequately reflect the Facility's practice standard for dental emergencies. The specific policy for dental emergencies did delineate the procedure that is practice at the Facility. Review of all reported dental emergencies indicated that a total of 36 dental emergencies were referred to the dental office for evaluation. Of the 36 individuals triaged by the dental office, 33 (92%) were evaluated and treated by the dentist, and three (1%) were evaluated by the dentist and treated by an oral surgeon. Effectively 100% of individuals referred for emergency dental evaluation were triaged appropriately. Furthermore, the dental records were reviewed for the last two dental emergencies (Individuals #757 and #87), and documentation indicated that the individuals were promptly and efficaciously treated, and that appropriate follow up occurred. The Monitoring Team determined that the Facility had an effective process to address emergency dental needs of individuals supported by the Facility. <u>Review of Integrated Progress Notes (IPN)</u> To assess the quality of dental notes in the IPNs in the clinical record, and to ensure that the notes were written in a way that could be understood by non-dental staff, and that they adequately reflected the dental issues that were addressed, the Monitoring Team reviewed the clinical records of Individuals #461, #66, #205, #737, #139, #520, #710,	

#	Provision	Assessment of Status	Compliance
		#244, #3, #362, #787, #247, #289, and #769. The Monitoring Team then requested copies of the last 10 dental notes that were placed into IPN. A total of ten IPNs were reviewed. The Monitoring Team determined that the quality of the dental notes in the IPNs was insufficient, and did not clearly delineate the clinical issues, follow-up plans, and issues relevant to providing medical and direct care to the individuals. For example, three out of 10 (30%) dental IPNs stated to refer to the dental section for information, and another two out of 10 (20%) dental IPNs were written only in dental terminology; hence, 50% were of no benefit to other staff, who rely on such info when performing necessary support services. <u>Summary</u> The Facility maintained an effective mechanism that ensured the delivery of emergency dental services, and maintained a robust staff of dentists; however, the Monitoring Team has significant concerns over the staffing of dental hygienists and assistants, and recommends that administration review staffing needs to ensure that the quantity of dental hygienists and dental assistants is adequate to support dental service needs. The Monitoring Team noted significant issues with regards to outcomes of oral health care and oral hygiene efforts, including the use of suction toothbrushing, that was provided at the living area, as there was a very high incidence of poor oral hygiene, plaque, gum bleeding, and calculus formation noted following review of dental summaries. For these reasons, the Monitoring Team determined that the Facility remains not in compliance for this provision.	
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;	Provision Q.2 addresses the Facility's provision of sedation for dental services, integration of dental services into the ISP and the community living discharge plan (CLDP), quality assurance measures for dental services, and interventions to minimize the use of sedation. <u>Review of Individual Support Plans (ISPs) for Inclusion of Dental Services</u> The Monitoring Team requested the ISPs for the last 15 individuals who had their annual dental examination completed as of 4/5/12, and before. The Monitoring Team also requested the most recent 10 completed ISPs, along with their dental summary; however, the dental summary was the only document the Facility provided. Because the ISP documents were not included, the Monitoring Team was unable to assess representation of dental services in the ISP process. <u>Review of the Dental Discharge Summaries used for Community Living Discharge Planning (CLDPs) Meetings</u> The Monitoring Team requested the dental summaries used for the most recent five CLDP meetings.	Noncompliance

#	Provision	Assessment of Status	Compliance
	interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	Based on review of the dental summary reports provided for review, the Monitoring Team identified, among other things, that the reports did not adequately reflect the individuals' oral health care issues; risks of not being provided adequate dental services; a clear understanding of what services and treatments were provided; the specific types of treatments required in the future, and when they should be obtained; or specifics about behavioral interventions that was required for oral health care and hygiene. <u>Use of General Anesthesia, Intravenous and Oral Sedation Use</u> The Monitoring Team requested a list of all individuals who were provided intravenous (i.v), oral, and general anesthesia for sedation purposes during dental treatments. The Facility indicated that 122 individuals required i.v sedation, and 35 individuals received Halcion, as an oral sedative, prior to receiving dental treatment. There were no individuals listed as requiring general anesthesia. Because there is no dental quality assurance program (QA) in place to evaluate positive and adverse outcomes of the use of sedation, the Monitoring Team determined that the Facility lacks that ability to effectively monitor and assess the use of sedation for dental services. A Dental QA process must be developed, that will include assessing the need for sedation and potential adverse outcomes, such as pneumonias, falls, and fall injuries, and behavior manifestations. <u>Review of the Dental Summary Forms</u> Review of the dental summaries provided for review demonstrated that the summaries provided some meaningful information that enabled team members to gain some insight into the individuals' oral health care issues and necessary supports needed to maintain satisfactory oral health. For example, the summaries clearly noted the extent of plaque and callus formation, and the extent of bleeding that occurred, and overall oral hygiene. The summaries also enabled the reader to understand what behavior issues interfere with treatments, and the type of behavior program and sedation necessary. The dental summaries did not clearly denote the actual type of restorative treatment that was necessary, and the time frame in which the treatment must be provided. Nor did they comment on the risks and benefits of providing dental services, versus not providing dental services, including medical, and potential behavioral complications. <u>Dental Desensitization, and Interventions to Minimize the Use of Sedating Medications, and Restraint</u> During its meeting with the dental director, the Monitoring Team was informed of a completely new approach that the Facility is taking to supporting behavioral challenges encountered when providing oral health care. The process includes the involvement	

#	Provision	Assessment of Status	Compliance
		psychology assistance, and the dental hygienist at the Facility. In collaboration with the dentist, the Facility identified 20 individuals who, based on their underlying behavioral issues, will undergo a skill acquisition development program, that will both enable desensitization, and teach the individual how to participate with oral health procedures. At the time of this review, the Facility had not developed a policy and procedure for the new process, and data was not available, as the process had just started. The Monitoring Team compliments and looks forward to reviewing implementation of this new approach. <u>Quality Assurance for Dental Services</u> The Facility had yet to develop core indicators to assess clinical outcomes of dental services. The Monitoring Team will assess outcomes, including adverse outcomes, following dental services during subsequent reviews. <u>Missed Appointments and Dental Scheduling</u> The Facility maintained a spreadsheet that lists all appointments that were missed and the reason the appointment was missed. The Monitoring Team did not request specific data during this review period on missed appointments, because the Facility is significantly changing its process to include an actual database for dental appointments. The database will enable a much more accurate, and real-time assessment of dental appointments. The Monitoring Team had an opportunity to review the new database, and compliments the Facility for moving forward by enhancing its ability to better manage data elements. <u>Summary</u> Because the Facility did not have an effective QA process to assess positive and adverse outcomes of dental services, did not implement an effective method to manage dental related to scheduling, missed appointments, and type of services provided and required, in addition to not enabling a robust process that ensures that dental services is adequately reflected in the personal support team process, the Monitoring Team determined that the Facility remains not in compliance with Provision Q.2.	

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

1. Ensure that all individuals are provided necessary skill acquisition techniques to perform their own oral hygiene, and when necessary, ensure that all individuals are supported by staff for their oral hygiene needs, including regular brushing, and when possible, flossing (Provision Q.1)
2. Ensure that all individuals at the Facility are assessed for the need of suction toothbrushes, and that there are well understood procedures for referring individuals for and implementing suction toothbrushing, following a change in their health care status (Provision Q.1)
3. Evaluate staffing needs specific to dental hygienists, and dental assistance (Provision Q.1)
4. The dental summary forms used must be enhanced to include issues including risk and benefits of dental services versus not performing dental

services, specific treatments received and required, along with time frames for completion, and that language that is understandable to non-dental office staff is used (Provision Q1)

5. The oral health care needs of individuals must be better expressed at the time of CLDP meetings. All clinical issues, all associated risks, time frame for completion of dental treatments and necessary treatments, must be clearly informed to the CLDP team (Provision Q.2)
6. Improve the dental IPNs so that they adequately reflect the dental services provided, necessary supports and follow-up plan, in language that is understandable to non-dental office staff (Provision Q.1)
7. Ensure that the new dental database is effectively implemented as soon as possible (Provisions Q.1, and Q.2)
8. Develop and implement a dental QA process that effectively assesses dental services, include adverse outcomes from sedation (Provision Q.2)

The following are offered as additional suggestions to the Facility:

1. Consider moving the clerical support area in the dental lab to a private area which would enable much needed room for the delivery of clinical care, and allow for private discussions among dental staff with guardians, and other health care providers (Provision Q.1)

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 Self Assessment 3/16/12 and Action Plans 3/8/12 2. Record Reviews: • Habilitation Sample #1: Individuals #175, #235, #373, #396, #461, #464, #478, #520, #576, #672, #741 and #752 • Habilitation Sample #2: Individuals #13, #42, #117, #119, #134, #235, #255, #298, #394, #519, and #534 • Habilitation Sample #3: Individuals #355, #476 and #679 • Habilitation Sample #5: Individuals #94, #153, #172, #204, #209, #578, #580 #669, #740 and #781 • Habilitation Sample #6: Individuals #11, #148, #175, #197, #347, #485, #565, #691, #707, #741, and #776 • Habilitation Sample #7: Individuals #105, #250, #269, #382, #469, #566 and #653 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 communication 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. DCPs (Houston Park, Cedar Falls and Eastfield) **Meeting Attended/Observations:** 1. Houston Park, Cedar Falls, Garden Ridge, and Eastfield Mealtimes and Transition Times
	Facility Self-Assessment: DSSLC's Self-Assessment, updated 3/16/2012, provided comments/status for Sections R.1 through R.4 of the Settlement Agreement. The Facility indicated it was not in compliance with Provisions R.1 through R.4. This was consistent with the Monitoring Team's findings as all provisions were found to be noncompliant. For the self-assessment, the Facility described, for each provision item, the activities engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. Overall, the Self Assessment and Action Plans included relevant steps that would assist in the state in gaining compliance; however, the activities at times were not consistently in line with what the monitoring

	team assesses as indicated in this report. Examples of this occurring included: ▪ Not all requirements of the Settlement Agreement had been reviewed. More specifically, within a sub-section, the Settlement Agreement might have numerous requirements, but only some were included in the Facility's Self-Assessment (e.g., Provision R.1 focused only on the hiring of staff and did not reflect the expected outcomes that would be seen by having adequate staffing.) If the Facility was choosing, for example, to prioritize assessing certain areas before others, that would be acceptable, but it should be stated specifically. ▪ Missing from Provision R.3 was information regarding the need to identify within the assessment as well as the ISP the functionality of the provided AAC devices. Overall, the Facility had demonstrated some good use of the data it had collected. Efforts to ensure the validity and reliability of the data will be important next steps, as will using the data to identify areas in which focused attention is needed.
	Summary of Monitor's Assessment: **Provision R.1:** This provision was determined to be not in compliance. DSSLC has increased their SLP staffing to full time which consists of 7.5 therapists, which in theory should be sufficient to carry out the daily tasks outlined in their policy as well as the SA. Due to this level of staffing just being achieved, more review is needed to determine of the increase in SLP staffing will result in improved participation and care as outlined in this provision. **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 new monitoring system that was just beginning to be implemented that covers the presence and condition of the device, implementation of the device, as well as SLP participation in care but this had just begun to be fully implemented. Many improvements were noted within this provision. Positives included in the increase in staffing from 3.5 to 7.5 and DSSLC's development of a monitoring system that will greatly assist them in determining the functionality of goals as well as staff's knowledge regarding the implementation of goals. Overall, there was much improvement as it relates to the development of processes and polices but the monitoring team has yet to see the implementation of these new processes on a wide scale. This is

	especially evident as it relates to the comprehensiveness of the communication assessments as well as the development of appropriate goals.

#	Provision	Assessment of Status	Compliance

R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	Sample #1 consisted of 13 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 sample was chosen by choosing every tenth name on the aspiration list and every fifth name on the choking at risk list.
		
		Individuals for sample #2 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 three individuals who accounted for 50% of the individuals who experienced a choking event and eight individuals who accounted for 100% of the individuals who experienced an aspiration event. The choking portion of the sample was gathered by choosing every other name on the DSSLC list.
		
		Sample #3 consisted of three individuals who accounted for 100% of new admissions since the previous compliance review.
		
		Sample #6 consisted of individuals on the list provided by the Facility as having severe expressive or receptive language disorders. The list totaled 110 individuals and the sample was drawn by selecting every tenth individual on the list.
		
		Sample #7 consisted of individuals receiving direct speech services and was drawn by selecting every other individual on the list provided by DSSLC.
		
		The Facility increased the 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 7.5 SLPs. This represented an increase of four SLPs since the previous compliance visit. One of the therapists was dedicated to the PNMT.
		
		General tasks in which Speech Pathology is responsible:
		• Attendance at:
		  • Pre-admission meetings
		  • 30 day planning conferences for all new admissions
		  • Annual planning conferences
		  • ISP meetings
		• Conduct/write Communication Assessments
			Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>

Provide direct treatment services
Maintain training data as applicable
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 1:77. This ratio should allow for the appropriate follow up or involvement of the SLP in all facets of the individuals care.
Although the current ratio appears to be sufficient in meeting the needs, there remained lack of SLP involvement in the development and monitoring of communication related goals and objectives. Per interview with the Speech and Language Director, this is an area that should begin to show improvement as full staffing was just recently achieved.
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<tr><td>R2</td><td>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.</td><td>
A communication master plan was provided to the Monitoring Team that outlines the assessment process. Per the master plan, all individuals would receive a revised comprehensive assessment by 12/31/2015. Individuals were assigned priority groups based on their level of communicative functioning and need. The priority groups were as follows:
<table>
<tr><td>Priority 1</td><td>Most dependent on others for their wants and needs (care code 3 or 4)</td><td>Complete</td></tr>
<tr><td>Priority 2</td><td>High risk for challenging behaviors (care code 3 or 4)</td><td>To be completed by 12/31/12</td></tr>
<tr><td>Priority 3</td><td>Individuals who have PBSP with a replacement behavior that does not include communication (care code 3 or 4)</td><td>To be completed by 12/31/13</td></tr>
<tr><td>Priority 4</td><td>Care code 3 or 4 who do not have a PBSP</td><td>To be completed by 12/31/14</td></tr>
<tr><td>Priority 5</td><td>Care code of 1 or 2</td><td>To be completed by 12/31/15</td></tr>
</table>
Care Code Legend:
1=no noticeable articulation problems and/or uses complex sentences
2=exhibits occasional articulation and/or uses only simple sentences
3=articulation problems are noticeable in speech and uses only phrases
4=speech is largely unintelligible by strangers and/or meaningful speech is absent or limited to a few simple words
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		The master plan also contain exceptions should an assessment be needed prior to the individual spot on the plan included: • Admission to the Facility • Transition or expected transition to the community • Significant changes in communication skills • Participation in therapy • Concerns with existing AAC • Referral by the IDT There was a plan was in place to provide all individuals with a communication assessment. Per review of samples #1, #2, #3, and #6, the assessments were not comprehensive as they lacked identification of communications strengths, consistent functional programs, and strategies to enhance or facilitate communication. Four of 18 (22%) individuals reviewed (sample #6 and #7) had appropriate communication goals. Examples of goals not being written appropriately or not written at all included: • Individuals #11, #707, and #347 communication assessment recommended an Environmental control (EC) objective but there was no evidence that these objectives were written. • Individual #776 had a communication goal that focused on her responding to the question "Do you want to sit in your recliner?" by activating an AAC device. Per review of the assessment, it stated that receptively, the individual was unable to comprehend this complex of a request; therefore the goal was not based on the findings of the assessment. • Individual # 148 was identified as having little to no expressive or receptive language but was not provided with any form of a communication program. The communication assessments for samples #1, #2, #3, #5 and #6 were not comprehensive enough to allow for the identification and potential expansion of communication skills. • In 15 of 45 (33%) records reviewed the assessment comprehensively addressed verbal and nonverbal skills and strengths. A positive was that the communication assessments did contain a statement regarding the need for services, but as stated previously, individuals were not always provided with the services they needed. • In 45 of 45 (100%) records reviewed the assessment addressed whether the individual requires direct or indirect Speech Language services.	

#	Provision	Assessment of Status	Compliance
		Another concern was that 12 assessments reviewed were generic in that they were identical with the exception of a few sentences. These assessments focused on the removal of AAC and implementation of EC. As stated above, many of these EC objectives were not implemented and none of the 12 had service objectives written that focused on object symbols as recommended in the assessment. Additionally, the recommendations for these 12 assessments were also identical. This similarity in assessments and recommendations represents a lack of an individualized communication assessment process. 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, three individuals were admitted to DSSLC. All individuals received a communication assessment within 30 days of admission. Zero of 11 Individuals (Sample #6) who had communication devices or programs were provided with the appropriate follow up of such devices or programs. For example: • Individuals #691 and #175 had AAC objectives but there was no evidence of monthly or quarterly review by the SLP or QMRP.	
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 seven of the 18 records (sample #6 and #7) reviewed (38%), 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 consistently written by the SLP. In zero of 11 records (sample#6) reviewed (0%), individuals with needs for language acquisition had goals/objectives/outcomes written and followed by the SLP. This resulted in goals not being functional or appropriate for many individuals. See Provision R.2 for additional information. ISPs 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 is need to not just restate the assessment but to draw connections to how	Noncompliance

#	Provision	Assessment of Status	Compliance
		the provided assessment and recommendations can be intertwined with all objectives and SAPs. Strategies to increase communication and understanding must be present in all aspects of care. o Individual #347's ISP contained a copy of the Communication Assessment but offered no integration into the individuals other plans (i.e., behavior, SAPs etc…) Three of the 45 records (samples #1, #2, #3, #5, and #6) reviewed (6%) had a clear rationale and description of communication interventions integrated into the ISP. Examples of ISPs in which communication was not adequately integrated included: o Individual #707's ISP simply stated that no speech treatment was needed rather than a description of communication. The ISPs 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: • Three of the 45 records (samples #1, #2, #3, #5, and #6) reviewed (6%) clearly identified how the individuals communicate with others and interact with their surroundings. Examples were provided in Provision R.3. General AAC devices were available in the common areas of most of the homes including 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 observed to be utilized in any of the observations.	
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	DSSLC had developed a monitoring form that tracked the presence and working condition of the AAC equipment as well as assist the SLP in monitoring the progress of goals on a minimum quarterly (in addition to monthly QDDP monitoring). This process was new and had just begun to be fully implemented; therefore more review at subsequent visits will be required. The Monitoring process will utilize the universal monitoring tool that is connected to PNM. This connection will allow for the acquisition of data regarding presence as well as implementation. An additional monitoring form will also provide information on SLP participation in IDT meetings and the implementation of new communication programs. Per observation and review, the current monitoring process was not effective in maintaining implementation of AAC devices, as demonstrated by the examples in	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Provision R3. DCPs were not knowledgeable of the communication programs as evidenced by: o In three of five interviews (60%), DCPs were able to locate adaptive equipment. o In zero of five interviews with staff (0%), staff could describe individual-specific communication strategies for the individuals they served. o In two of five interviews with staff (40%), staff could describe the schedule for implementation of communication strategies. o In two of five interviews with staff (40%), staff stated they had received individual-specific training for communication strategies.	

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

1. Many recommendations appeared to be left to the IDT 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. Individual communication programs should be integrated into ISPs through skill acquisition programs, as well as PBSPs (when appropriate), to ensure the AAC device or mode of communication is meaningful to the individual and the individual can communicate and be an active participant in multiple environments (Provision R.3).
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 as an addition to monthly review by the assigned IDT member) This level of review should be in addition to the normal monthly monitoring that is provided by the QMRP.. (Provision R.2)
4. Communication assessments must do a better job at identifying strengths of the individual and methods to enhance communication in the contexts of a 24 hr day. (Provision R.1)

The following are offered as additional suggestions to the Facility:

1. The Communication Department would still benefit from additional support (primarily in the form of clerical staff) to assist with the data entry aspect of the monitoring system to allow the SLPs more time to conduct clinical work rather than clerical work. (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. DSSLC Self-Assessment 3/16/12 2. DSSLC Action Plan 3/8/12 3. DSSLC Presentation Book for Section S 4. Documents that were reviewed included the annual ISP, ISP updates, Skill Acquisition Programs (SAPs, 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 Self-assessment and included the following individuals: #24, #63, #68, #89, #102, #105, #108, #110, #119, #127, #131, #141, #147, #148, #149, #161, #165, #183, #204, #208, #213, #217, #226, #229, #231, #277, #288, #295, #297, #306, #311, #319, #320, #323, #326, #327, #335, #380, #391, #402, #430, #451, #452, #469, #482, #494, #505, #510, #512, #539, #545, #560, #562, #563, #594, #616, #619, #637, #653, #679, #694, #726, #729, #731, #737, #768, #774, #776, and #781. **People Interviewed:** 1. Linda Ford – Director of Active Treatment 2. Trent Lewis – Vocational Services Director 3. Pung Nelson – (Not sure of her new title. Was just being brought on to help Linda) 4. Randy Spence, MS – Director of Behavior Services 5. Jill Wooten, MS, BCBA – Psychologist 6. Approximately 30 direct care staff in the following residences and day treatment areas: 505A, 506C, 508A, 508A, 509A, 522A, 522B, 522C, 522D, 522D, 523A, 523A, 523B, 525A, 525A, 525B, 525D, 526A, 526A, 526B, 526B, 526C, 527A, ICD 120, ICD 124, ICD 128 **Meeting Attended/Observations:** 1. Active Treatment Meeting – 4/5/2012 2. Human Rights Committee Meeting – 4/4/2012 3. Positive Behavior Support Committee – 4/5/2012 4. The following residences and day treatment areas: 505A, 506C, 508A, 508A, 509A, 522A, 522B, 522C, 522D, 522D, 523A, 523A, 523B, 525A, 525A, 525B, 525D, 526A, 526A, 526B, 526B, 526C, 527A, ICD 120, ICD 124, ICD 128
	Facility Self-Assessment: At the time of the site visit, DSSLC reported that no Provision was in substantial compliance with the SA. The Monitoring Team was in agreement with the Facility. The Facility provided two documents intended to present the status of current efforts to comply with the

	Settlement Agreement. The first document was a Self-Assessment that was to reflect the Facility's appraisal of progress toward compliance with the Settlement Agreement. The most noteworthy aspect of the DSSLC Self-Assessment was the broad and general approach to assessing the status of the Facility. The Self-Assessment reported the percentage of SAPs that were rated as in compliance, but did not reflect an effort to investigate and identify the underlying reasons why more SAPs were not in compliance. Furthermore, nowhere in the Section S was there an examination of how assessment information regarding individuals was obtained and integrated into the development of the SAPs. Without a more precise review process that is closely aligned with the Settlement Agreement, DSSLC will continue to struggle in attempting to achieve substantial progress. The second document was the Action Plan that outlined the steps the Facility had identified as critical to satisfying the Settlement Agreement. The Section S Action Plan presented by DSSLC included a number of goals that the Facility planned to obtain. In many cases, however, these goals were not part of a larger, integrated plan for improvement and compliance. Rather, the Action Plan steps were discrete and often general goals that reflected neither an organized approach to improvement nor a clear understanding of what the Facility hoped to achieve. For example, the Action Plan for Provision S3 included the goal of discussing the need to increase the employment hours for individuals, followed by the goal for all individuals in several residences to begin working five days per week, six to eight hours per day. The Action Plan included no specific process that would lead to the satisfaction of this goal. Compliance with a Settlement Agreement requires that the Facility invest considerable effort into taking the guidelines in the Settlement Agreement and identifying the specific actions necessary to meet those requirements. In many ways, the Settlement Agreement requires that the Facility complete a task analysis on each provision and use that task analysis to formulate an action plan.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at DSSLC from 4/2/2012 through 4/6/2012. Record reviews continued off-site following the site visit. Based upon information gathered during the current site visit, it was apparent that no provisions of Section S were in substantial compliance with the Settlement Agreement. The site visit revealed instances where the Facility had demonstrated both creativity and improvement. DSSLC had recently opened Impressions, a retail outlet where crafts and artwork created by individuals living at the Facility would be sold to the general public. In addition, plans called for Impressions to be used as a training site where individuals would create items to be sold as well as practice skills beneficial for transitioning to community living, such as retail sales skills, socialization, and money management. There were also activities observed at the Facility that reflected staff offering consistent supports and encouragement to individuals engaged in vocational and recreational programming. In addition, the Facility had maintained relatively high levels of community outings. The areas of noted improvement and success, however, were isolated occurrences rather than a reflection of an intensive and organized approach to improvement. In many of the residences at the Facility,

	individuals were offered minimal supports or opportunities for learning. Skill acquisition programs, although provided a new format, lacked many of the elements essential to learning. Assessments of individual needs, strengths, and preferences were often not conducted, and those assessments that were conducted frequently were not used in the development of skill acquisition programs. Furthermore, the ISP process often failed to ensure that the needs of individuals were addressed. In order to ensure that all individuals living at DSSLC are provided the necessary assessments, training, and support, an intensive and well-organized system will be required. Such a system is not yet in place.

#	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.	<u>Use of Assessment Information in Planning Skill Acquisition</u> Adequate assessment is essential for understanding an individual's abilities, identifying specific needs, and determining the strengths upon which new skills can be based. Without thorough and comprehensive assessments, skill acquisition training is unlikely to be successful or meaningful to the individual who is to participate in the training. During the initial March 2010 baseline site visit, it was noted that none of the 10 individuals included in the skill acquisition training sample had been provided with all of the necessary assessments. Several individuals had received medical or psychological assessments, but lacked assessments targeting mental illness, communication or adaptive behavior. During the current site visit, 13 individuals were selected by the Monitor in order to compare Skill Acquisition Programs with relevant assessments. These individuals were selected from the list of individuals with the most recent ISPs. At the request of the Monitoring Team, the Facility provided examples of academic, communication, hygiene, money management, and work SAPs. The most common process used at DSSLC to assess adaptive skills and habilitative needs was the Functional Skill Assessment (FSA). 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. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		individual's physical, developmental, cognitive, and environmental circumstances. Without the ability to capture the basic information about individual abilities within these contexts, any 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. Other assessment procedures in addition to the FSA were implemented at DSSLC, such as the Personal Focus Assessment (PFA), ratings of adaptive behavior, and various intellectual assessments. In addition, several disciplines, such as Medical, Nursing, OT/PT, Psychiatry, and vocational services conduct assessments. Despite the available assessments, there were few indications that the ISP process was used to compile assessment findings and utilize those findings in selecting the appropriate training programs. The table below reflects the findings of the current review.	

	03/2010	04/2012	Change
Skill acquisition plans are implemented to address needs identified in:			
ISP	0%	0%	0%
Adaptive skill or habilitative assessment	0%	0%	0%
Psychological assessment	0%	0%	0%
Skill acquisition plans are chosen in an individualized manner.	0%	0%	0%
Skill acquisition plans are related to the individual's preferences.	0%	8%	8%

It was striking the infrequency with which the Facility acted to ensure that assessment findings were reflected in actual SAPs. The reviewed PSPs seldom presented assessment findings in relation to teaching new skills. Furthermore, in several instances, the assessment information that was presented did not support the training goals or SAPs that had been developed for the individuals in the sample.

- The ISP for Individual #108 indicated the individual was at risk due to weight and should be encouraged to eat foods that were healthy. The SAP developed to

#	Provision	Assessment of Status	Compliance
		support this need involved teaching the individual to cook. Although reference was made to healthy eating in the SAP, the only element of the SAP relating to healthy eating was requiring the individual only prepare foods listed on the approved menu. Requiring a person to select foods from a list is unlikely to help the person identify and select generally healthy foods. It would have been more appropriate to teach the individual how to make healthy food choices or how to select cooking strategies that support healthy eating. • Individual #148 was provided an SAP to increase hand sanitation prior to taking medications. The Nursing Assessment discussed in the ISP, however, reflected that the individual receives all medications via a feeding tube. It was therefore unclear how the SAP was meaningful for the individual or upon what basis it had been selected. • Individual #297 was provided an SAP to teach looking both ways before crossing the street. The Functional Skills Assessment (FSA) reflected that the individual possessed and demonstrated the ability to cross streets independently. • Individual #637 was provided an SAP relating to work performance at the vocational workshop. The ISP did not present information indicating the individual experienced difficulties at the workshop. Rather, the ISP discussed how the individual had held a community job but returned to a workshop job. The reasons for the change in jobs included being able to work near friends, a preference for workshop employment, and the opportunity to make more money. The Facility also displayed a pervasive lack of incorporation of individual preferences into SAPs. No formal preference assessments were documented in any ISP, although individuals were administered a PFA. The PFA is a rating tool intended to identify personal preferences. Preferences identified through the PFA were noted to be entirely subjective and frequently based upon anecdotal evidence. Furthermore, references to the PFA in the ISP were, at best, sporadic. The lack of an adequate preference assessment was particularly concerning in relation to reinforcement for successful display of a skill. Reinforcement is essential for learning and must reflect the unique motivations of the individual. For the vast majority of SAPs reviewed, the reinforcement for a successful display or trial was verbal praise. It is not uncommon for verbal praise to function as a reinforcer. When virtually all SAPs include the same reinforcer, however, the probability of an individualized preference assessment being conducted is very low. Undoubtedly, for some individuals at DSSLC, the verbal praise did function as a reinforcer. Due to the lack of adequate preference assessment, however, those occurrences most likely reflected chance or coincidence. Based upon the examples noted above, it was apparent that DSSLC was frequently unable to ensure that assessment findings were used in the development of skill acquisition	

#	Provision	Assessment of Status	Compliance
		programs. When combined with the limitations in the design of the FSA and the PFA, it was evident that an individualized and evidence-based approach to program development was not utilized at the Facility. As a result, the Facility lacked the ability to ensure that individuals living at DSSLC were provided with meaningful and functional skill acquisition training. Teaching New Skills Teaching new skills requires the use of the same learning principles involved in changing undesired behavior. Therefore, effective skill acquisition programs require 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. In September 2011, skill acquisition programs (SAPs) for 25 individuals identified improvement in several areas of the skill acquisition programs, such as task analyses, discriminative stimuli, and opportunity for the display of targeted tasks. At the same time, many weaknesses in SAPs noted in previous site visits continued, such as: target behaviors and skills lacked operational definitions, teaching procedures lacked sufficient specificity to ensure consistent implementation, training sessions were too infrequent, and no strategy for generalization was identified. During the current site visit, 69 individuals were included in a sample of SAPS. For each individual, at least two SAPs were reviewed. A portion of the review process included an audit of the ISP and assessments used by the Facility to identify individual training needs. Based upon the review, it was evident that the Facility had failed to achieve and consistently maintain progress beyond the conditions observed during the initial site visit in March 2010. Although there were areas in which performance was better than that observed during the baseline visit, only in the area of opportunities for target behaviors to occur was substantial progress maintained. The table below reflects the status of assessments noted during the current site visit. Area | 3/2010 | 9/2011 | 4/2012	

#	Provision	Assessment of Status				Compliance
		Plan reflects development based upon a task analysis	0%	57%	0%	
		Behavioral objective(s)	0%	40%	8%	
		Operational definitions of target behavior	0%	11%	8%	
		Description of teaching conditions	0%	11%	0%	
		Schedule of implementation comprised of sufficient trials for learning to occur.	0%	0%	23%	
		Relevant discriminative stimuli	0%	77%	23%	
		Specific instructions	0%	6%	0%	
		Opportunity for the target behavior to occur	0%	94%	69%	
		Specific consequences for correct response	100%	89%	0%	
		Specific consequences for incorrect response	0%	0%	0%	
		Plan for maintenance and generalization that includes assessment and measurement methodology	0%	0%	0%	

Based upon information reviewed, there were areas of improvement in relation to SAPs at DSSLC. The new format for the SAPs was structured so that sections were provided for several essential components relating to skill acquisition training, such as targeted skills, consequences for correct and incorrect responses, and training materials. Although the information provided in these sections was often inadequate, it was an improvement that the format included provisions for the necessary elements.

A second area of improvement noted during the current site visit was the inclusion of sufficient opportunities for the target skill or behavior to be displayed. Previously, SAPs did not often include opportunities for the individual to engage in the behavior being taught. In the current sample, slightly more than two-thirds of all reviewed SAPs did include such opportunities. Although this reflected an improvement in comparison with practices in March 2010, it was concerning that the Facility had failed to completely maintain previous gains.

Despite these improvements, DSSLC had failed to improve or had regressed in several areas. The following specific issues were noted during the review of skill acquisition programs.

Sequential training and task analysis. In the majority of SAPs, the Facility had opted to use sequential training. Sequential training is the process of breaking down a complex task into several steps and the teaching those steps in forward or reverse order. This is a well-established process for teaching new skills. SAPs at DSSLC, however, often did not reflect adherence to the basic principles of sequential training.

#	Provision	Assessment of Status	Compliance
		When using sequential training methods, it is essential that a task analysis be completed. A task analysis is the formal process of dividing the complex skill into smaller, teachable units according to the unique needs of the individual who is to be taught. Staff at DSSLC reported that task analyses were often completed, but that the process was not documented, and that specific procedures or tools were not used. The content of SAPs developed at DSSLC, however, often did not reflect the results of task analyses. In many instances, the training steps did not reflect a sequential progression through a complex task, instead providing only a list of discrete behaviors or performance requirements. In addition, single steps often required the individual to perform several behaviors: it was not clear that the individual possessed the ability to perform all behaviors in the step. • For Individual #297, the steps of a mathematics SAP reflected multiple discrete tasks rather than a sequential progression through a complex task. 1. The Individual will match and count 5 pennies to 1 nickel 2. The Individual will match and count 10 pennies to 1 dime 3. The Individual will match and count 2 nickels to 1 dime 4. The Individual will match and count 3 nickels to 1 dime and 1 nickel • A SAP for Individual #563 reflected the complex task of placing a phone call and conducting a conversation by phone. These steps, however, were vague and could not effectively be taught as sequential steps due to the interactive process of participating in a conversation. 1. The Individual will talk to her family by telephone 2. The Individual will listen to her family talk to her by telephone 3. The Individual will push the correct buttons on a telephone to call her family • A SAP for Individual #451 to begin work did not reflect the steps of a complex task although it was presented as a sequential training program. Instead, the SAP emphasized compliance with a single request to start working within increasingly shorter durations. • Individual #482 was provided a SAP for brushing teeth. Although four sequential steps were presented, each step involved several behaviors. The FSA for the individual indicated he possessed only the ability to identify his personal toothbrush. 1. Will gather all materials 2. Will brush upper teeth 3. Will brush lower teeth 4. Will rinse toothbrush, rinse mouth and put away materials <u>Behavioral objectives and definitions</u>. It is essential that efforts to strengthen skills include specific behaviors or skills to be increased, the level of success that the individual is	

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		expected to achieve, and the time within which that success would be achieved. In addition, it is important for objective statements to be clear and precise. Frequently, goal statements lacked the content and precision necessary for goal statements. As a result, it often was not possible to identify what was expected from the individual or how progress was to be measured. • For Individual #108, the goal statement for writing a check was, "With no more than 1 verbal prompt, [the individual] will a check [sic] on Friday's 95% of all trials for three consecutive periods by 6/18/2012." • For Individual #391, the goal statement involved the individual choosing clothing by looking at the preferred item. It was not clear from the objective or methodology what constituted "looking at" the preferred item. In order to communicate a choice through "looking", specific conditions should be included to make things clear. It would have been helpful to define how long the individual was required to maintain visual focus upon the item. In addition the distance between the items of clothing and the individual, the distance between the presented items, and the manner in which the items were presented could substantially affect the determination of choice. It would be much more difficult to determine which of two items the individual had chosen if the individual glanced at one of two items presented 18 inches apart and eight feet from the individual than if the items were 30 inches apart and three feet from the individual. • For Individual #512, the goal statement for putting away clothes consisted of, "When given the instruction ""Put your clothes away"" and given two items each for top, middle and bottom dresser drawers, with items sorted by category and folded, the individual puts items in correct drawers for 28 out of 36 data points." Although this statement could encompass all tasks the individual was expected to perform, it did not provide sufficient clarity. For example, was the individual supposed to sort the items by category or was that how the items were to be presented? Was the individual to be presented with the items individually or in a stack to be sorted and put away accordingly? If the intent of the SAP was to teach the individual to put clothes in the correct drawers upon request, the remainder of the information belonged in staff instructions rather than in a statement describing what the individual was to be taught. <u>Description of teaching conditions</u>. 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 may be 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	

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		that training would be implemented consistently. • For example, for Individual #127, the SAP for self-help skills described the teaching environment conditions as "Natural training environment." In addition, the materials required for teaching were very general, such as "cleaning supplies." • For Individual #737, instructions for staff consisted only of the following information: "Book. Staff will read to [the Individual]. Staff will instruct: "Listen to this rhyme, poem, story as I read it to you". These instructions did not provide staff with specific information about seating arrangement (side-by-side or face-to-face), the location within which the reading was to occur, the speed with which the material was to be read, or how loudly or softly staff were to read. Depending upon the needs of the individual, any of these conditions could influence whether or not the individual was successful. • Individual #452 was provided a SAP for looking both ways before crossing the street. The SAP included general instructions for prompting to look both directions, but did not indicate where the training was to be conducted, such as a street at the Facility or in downtown Denton. In addition, the SAP includes the following potentially problematic statement, "Practice crossing under variety of traffic conditions, so that student really learns to watch for cars, not just to turn head back and forth". This statement could be interpreted to mean that streets that presented a challenge due to high traffic volume should be selected for training. <u>Sufficient trials</u>. 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. The rate of reinforcement may later be reduced as the individual develops mastery. If the rate for reinforcement opportunities falls too low or too quickly, however, that specific reinforcement may not successfully compete with other reinforcement in the environment. Under such circumstances, learning could be inhibited or skills lost. In the majority of skill acquisition programs reviewed at DSSLC, the SAPs did not specify the number of teaching trials to be provided. <u>Consequences for correct and incorrect responses</u>. The majority of training programs at DSSLC included the provision of potential reinforcement following a successful display of the target behavior. As discussed earlier in this Provision, the majority of SAPs relied upon verbal praise as reinforcement although no formal reinforcer assessment supporting verbal reinforcement had been completed. An additional weakness found in many SAPs involved the criteria for reinforcement being, "When the individual responds to training." "Responding to training" was a very general term and could have included success or refusal to participate, as both constitute a response. If implemented as written, many of	

#	Provision	Assessment of Status	Compliance
		the SAPs at DSSLC would have required reinforcement for behaviors other than the successful completion of the task or task step being trained. For training to be effective 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. Many of the training programs reviewed at DSSLC included instruction to staff regarding consequences for incorrect responses. The prescribed response, however, was typically to correct the incorrect attempt. There was no indication in any reviewed SAP that consideration had been given to functions such as attention or escape for incorrect attempts or refusal. • For Individual #653, a SAP for cleaning prescribed the following consequences: "If [the Individual] responds incorrectly, provide assistance to complete the task. If [the Individual] does refuse, respect his answer and attempt at another meal time or snack time." If functional assessment indicated attention as reinforcing, assistance to complete the task might increase errors. If functional assessment indicated escape from tasks as a reinforcer, permitting the person to avoid completion might reinforce refusals. These instructions, which provide opportunities for reinforcement of incorrect responses related to two different functions of behavior, do not show that these functions were considered. <u>Data collection</u>. 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 be provided specific and detailed instructions. The majority of SAPs at DSSLC provided no instructions for data collection other than the code to use for recording a prompt level. It was also common to discover SAPs that provided only a schedule for data collection. • For Individual #108, an SAP for food preparation did not specify a procedure for collecting data. <u>Timeframes for success</u>. Providing a target date as well as an expected level of performance in skill acquisition training establishes a framework within which progress can be measured. The purpose of skill acquisition programs is to strengthen new skills; therefore, a measure of progress is important. In addition, however, expectations for success help to ensure that learning occurs at an adequate pace. Continuing training beyond mastery of the skill in many	

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		situations has little benefit for the individual and may create a situation in which participating in training is punishing. One limitation in the SAPs reviewed at DSSLC, involved excessive durations beyond mastery before the program could be considered completed. • For Individual #277, an SAP for signing in at work required the individual to, "sign-in upon arrival when her job coach hands her the sign in sheet, for 16 out of 20 data trials for three consecutive recording periods." This required a demonstration of mastery for a minimum of three months before increasing the behavioral complexity or independence required in the goal. • For Individual #306, an SAP required that the individual use a calculator to solve an addition or subtraction problem by a deadline one year from the SAP implementation date. The SAPs at DSSLC also often failed to include any time frame for completion or included measures other than time that were not defined in the SAP. • A medication management SAP for Individual #119 defined completion as correct responding for 75 out of 84 data points. • An SAP for Individual #482 required successful attempts for 80% of trials, but did not indicate any time frame, number of opportunities/days for which 80% of trials must be successful, or target date. Based upon the information obtained during the site visit, it was evident that DSSLC was unable to ensure that the individuals living at the Facility were provided with adequate learning opportunities. Furthermore, the status of skill assessment and skill acquisition training had not appreciably improved since the baseline visit in March of 2010. | | 03/2010 | 04/2012 | Change | | Overall, the set of skill acquisition programs promote growth, development, and independence | 0% | 0% | 0% | 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. <u>Implementation of formal and informal skill acquisition training</u> During all previous site visits, pervasive problems were noted regarding the	

#	Provision	Assessment of Status	Compliance

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 September 2011 site visit, observations reflected that the provision of active treatment in the individual apartments fell far below acceptability. Functional engagement was noted for 58% of all individuals, including those in high engagement settings such as meals and small classrooms. In several settings, however, staff was notably unfamiliar with individuals and training programs. In other settings, the lack of active treatment placed some individuals at risk of personal harm.

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 functional activity.

	Staff Present	Individuals Present	Individuals Functionally Engaged	Percent Functionally Engaged
ICD 124	3	12	9	75%
ICD 128	5	23	8	35%
ICD 120	3	4	4	100%
508A	3	5	2	40%
522A	1	5	0	0%
522B	2	7	0	0%
522D	2	6	0	0%
523A	1	2	0	0%
522C	3	1	0	0%
525A	3	1	0	0%
525B	2	4	0	0%
525D	3	1	0	0%
526A	1	3	0	0%
526B	2	3	0	0%
523A	1	5	0	0%
523B	1	5	0	0%
525A	2	5	0	0%

#	Provision	Assessment of Status	Compliance

526A	1	3	3	100%
526B	2	5	5	100%
526C	3	6	5	83%
522D	2	5	2	40%
508A	2	7	3	43%
509A	1	4	1	25%
527A	2	5	1	20%
505A	1	6	2	33%
506C	2	4	0	0%
	54	137	45	
Total percentage of individuals functionally engaged				33%
Percentage of locations with greater than 50% functional engagement				19%

Based upon the observations conducted during the current site visit, it was evident that overall functional engagement had dropped from 58% to 33% of individuals. Furthermore, only five of the 26 observed locations (19%) reflected functional engagement at or above 50% of individuals. These data suggested that DSSLC continued to experience substantial difficulty in ensuring that individuals were provided with meaningful activities.

As noted in the data table above, some locations at DSSLC were observed to have high levels of functional engagement. In these settings, not only were functional activities provided, but staff was also observed to interact with and support the individuals present.

- In ICD room 120, four individuals were engaged in art projects involving stained glass. All individuals were actively participating and staff frequently offered praise and encouragement.
- In ICD room 124, nine of 12 individuals (75%) were independently working n vocational tasks. Although no formal training was noted, staff did offer informal prompts.
- In 526B, five of five individuals (100%) were actively engaged in dining. Staff were noted to offer prompts for positioning and to slow the rate of eating.

During the September 2011 site visit, the lack of active treatment and functional engagement was considered sufficient to place individuals at risk of harm. Conditions during the current site visit were marginally improved. Nevertheless, several settings failed to provide a minimal level of engagement.

- In residence 522B, seven individuals were provided no interaction or materials for functional activities. Of the seven individuals present in the living room, one was asleep, one was rhythmically rocking and one was masturbating.
- In residence 522C, one individual was asleep in a chair while three staff were

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		socializing near the desk. Upon inquiry, staff reported that all other individuals living in the residence were in bed asleep. This was at 4:22pm. • In residence 523A, one man was participating in a medical procedure in front of five peers. One of the peers was not wearing a shirt and was crawling around on the floor. A second peer was seated in a wheelchair while rubbing and slapping his head. No materials or activities were available. • In residence 525A, five individuals were observed prior to and during the evening meal. Individuals were eating potato chips immediately prior to the meal. No hand washing or meal preparation was noted prior to dining. During the meal, one individual pointed to a preferred food: he was told to stop. No individuals were prompted or encouraged to serve themselves, including one man who had been observed independently engaging in a variety of tasks. • In residence 508A, only three of seven (43%) individuals were functionally engaged. Of the remaining four individuals, one repeatedly bit her hand and slapped her face, one engaged in persistent bruxism, and a third was vocalizing while rhythmically rocking. Staff was noted to observe each individual but offered no engagement or interruption. DSSLC staff reported that audits of engagement were conducted. Documentation provided by the Facility reflected engagement ratings of between 50% and 90% since September 2010. As the Facility indicated that too few audits were completed to provide a meaningful measure, it was not possible to compare Facility ratings with those achieved by the Monitor during the current site visit. Based upon data collected from observations and record reviews during the current site visit, it was apparent that the Facility did not have the ability to monitor functional engagement or ensure that individuals were provided with active treatment. Furthermore, evidence regarding the quality of skill acquisition programs clearly reflected an inability to provide formal training and supports. Without the means to ensure either formal or informal services, conditions extant at the Facility during the current site visit reflected no overall progress in comparison with baseline conditions.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	During the baseline site visit in March 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 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	Noncompliance

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		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 13 individuals living at DSSLC. This review revealed considerable weaknesses in the annual assessments for all individuals. None of the individuals included in the review had been provided all necessary assessments. Where assessments were provided, the assessments often did not reflect objective and valid assessment procedures. As a result, none of the individuals included in the review had been provided with comprehensive assessments that adequately measured preferences, strengths, skills, and abilities. • As discussed in the previous provision, the FSA often lacked the ability to provide meaningful information about skills and abilities. • Although the format of the SAPs suggested a task analysis was conducted, no documentation of task analyses existed. • Only 4% of individuals living at the Facility had a Psychological Evaluation completed within the past five years. • Many individuals were provided with updates to vocational assessments when no original vocational assessments existed to be updated. • No formal preference and reinforcer assessments were conducted. The subjective and anecdotal assessments were not integrated into SAPs. • Although submission of assessment reports to the QDDP was required 10 days prior to the ISP meeting, 54% of assessments were not submitted by the target date. • There was little evidence to support that assessment findings were adequately reviewed during the ISP meeting and integrated into the SAPs. Based upon observations and record reviews conducted during the current site visit, the Facility was not providing a comprehensive assessment each year for individuals living at DSSLC. Assessments of intellectual and adaptive ability were seldom performed or reviewed, and the FSA lacked the rigor necessary to accurately identify specific, task-related strengths. This limited the PST in efforts to adequately identifying personal strengths and to recognize the ability of each person to engage in routine activities associated with independence and self-care. Other assessments, such as vocational assessments, were incomplete. Even when assessments were conducted, Facility records reflected that only 46% were submitted in time for integration into the ISP. Therefore, although some aspects of the assessment process could have resulted in a valid and reliable measure of a narrow aspect of an individual's abilities, the means were not available to ensure accurate and comprehensive assessments were provided on a consistent basis. As a result, the Facility had achieved little progress beyond baseline	

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		conditions.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	Due to the limitations noted in Provisions S1 and S2, it was frequently not possible to determine if training programs addressed pertinent needs of the individual. Without accurate and comprehensive assessment, it was not possible to clearly identify the specific needs of the individual and establish specific teaching goals from which to measure progress. As a result, it was probable that DSSLC did not possess a clear measure of each individual's strengths and needs, and could not develop, monitor, or revise training programs with accuracy. During the current site visit, DSSLC reported that SAPs were implemented correctly during 58.2% of observations conducted since September 2011. Observations conducted by the Monitoring Team, however, had failed to capture the implementation of any SAPs. Due to the discrepancy between data provided by the Facility and those obtained by Monitor observation, interviews with 25 staff were conducted to gather additional information. These interviews revealed that staff were familiar with SAPs and had been provided support and training on SAP implementation. Based upon the information obtained during the current site visit, the Facility had not progressed substantially beyond baseline conditions.	Noncompliance
	(b) Include to the degree practicable training opportunities in community settings.	At the time of the March 2011 site visit, DSSLC had generally increased the total number of community activities compared with the same time frame from the previous year. A trend analysis, however, reflected a steady decline in the number of community activities in the First Quarter of 2011. The September 2011 site visit, however, revealed that the Facility had reinvigorated the community activities process with a substantial increase in outings. During the current site visit, trends in community outings revealed that community outings have remained at relatively high levels, although there appears to be a gradual decline in the number of outings since September 2011.	Noncompliance

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		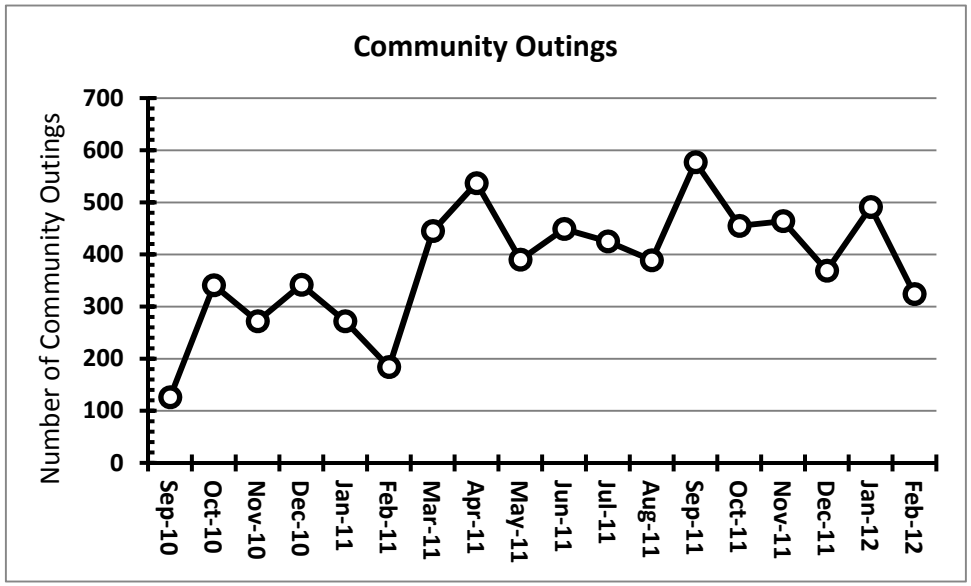 Some changes were noted in community employment for individuals living at DSSLC. During the previous site visit, 11 individuals were employed in the community. During the current site visit, that number had dropped to eight individuals with community jobs. The site visit revealed instances where the Facility had demonstrated both creativity and improvement. DSSLC had recently opened Impressions, a retail outlet where crafts and artwork created by individuals living at the Facility would be sold to the general public. In addition, plans called for Impressions to be used as a training site where individuals would create items to be sold as well as practice skills beneficial for transitioning to community living, such as retail sales skills, socialization, and money management. As Impressions was relatively new, it was unclear how many individuals from DSSLC were actively involved in the program. The intent, however, was to use the program as a retail outlet and training site. This provision of the Settlement Agreement addresses not only the quantity of community opportunities, but the provision of training in the community as well. In discussions with staff it was reported that many community outings include the implementation of SAPs. At the time of the site visit, however, there was not a system to track the number of actual training opportunities in the community or progress achieved through community training. It was also noted that the same issues that limited effective skill acquisition	

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		programming at the Facility, as discussed in Provisions S1 and Section 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 of learning and reflect an evidence-based approach to the process of strengthen skills and abilities. (Provision S1)
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. (Provision S2)
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. (Provision S2)
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 both at the Facility and in community settings. (Provision S3)

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 11. Denton State Supported Living Center (DSSLC) Self-Assessment, updated 3/16/2012 12. Denton State Supported Living Center Report for Monitors, dated April 2, 2012 13. Denton State Supported Living Center Action Plans, updated 3/18/2012 14. Section T Presentation Book materials 15. Draft DADS Policy 018: Most Integrated Setting Practices, undated 16. DADS Policy 004: Personal Focus Assessment, dated 09/01/11 17. Community Integrated Discussion Record, revised 03-2010 18. DSSLC Policy Client Management 39: Most Integrated Setting 19. DADS Policy 004 Personal Support Plan Instructions, dated 7/30/10 20. DSSLC Policy CMGT-12.01 Personal Support Planning Process, dated 1/3/11 21. DSSLC Policy CMGT-12.01 Personal Support Planning Process Pilot Project Personal Focus Assessment and Facilitation, dated 8/5/11 22. Since last on-site review, a list of all individuals who have requested community placement, but have not been referred for placement 23. 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" 24. Since last on-site review, a list of all individuals who have died after moving to community living 25. A current list of all alleged offenders committed to the Facility following court-ordered evaluations 26. For the last twelve months, a list of individuals who were reported to have been assessed for placement 27. Community Placement Report, dated March 01, 2012 28. For the last twelve months, lists of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices 29. Annual Report: Obstacles to Community Transition, Fiscal Year 2011, Data as of 8/31/2011 30. Since last on-site review, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed 31. Mental Retardation Authority (MRA) Community Living Options Information Process (CLOIP) Worksheets for individuals who had ISPs during March 2012 and the week of April 2, 2012 32. Individual Support Plans/Personal Support Plans (ISPs/PSPs) and Personal Focus Assessment (PFA) for Individuals #122, #235, #336, #511, #537, #588, and #742 33. Completed CLDPs for Individuals #236, #384, #458, #683, and #771 34. Partial CLDPs for Individuals #275, #354, #381, #493, and #494 35. Community placement medical review memos for Individuals #217, #229, #232, #238, #354, #381, #432, and #493 36. Pre Move Site Reviews for Individuals #236, #384, #458, #683, and #771

	37. MRA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for Individuals #236, #384, #458, #683, and #771 38. Completed Post Move Monitoring (PMM) checklists for Individuals #77, #124, #236, #266, #384, #458, #634, #683, #751, #771, and #792 39. Discharge packets for Individuals #374 and #657 40. Minutes of Self-Advocacy meetings held during the last six months 41. QA/QI Council Meeting: Data Analysis Report, Sections F. R, S, T, U, V and M, dated February 21, 2012 **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. Lori Powell, Director of Quality Assurance 5. Linda Wilson, QA Auditor 6. Berry Sudderth, QDDP (Qualified Developmental Disability Professional) Auditor/Personal Focus Interview (PFI) Interviewer **Meeting Attended/Observations:** 3. ISPs for three Individuals: Individuals #1, #53, #464 4. Personal Focus Assessment/Interview (PFI) meeting for Individual #381, #53 5. Post-Move Monitoring Visit for Individual #458
	Facility Self-Assessment: The Monitoring Team reviewed the DSSLC Self-Assessment. The current Self-Assessment reported on the activities engaged in to conduct the self-assessment, provided its assessment of the results of the self-assessment and finally provided a self-rating stating why or why not it believed compliance had been achieved. The Facility had begun in some instances to couple the self-assessment with its internal quality assurance processes to assess ongoing progress toward completion and the actual outcomes. Development of additional measures may still need to occur. **For Provision T1**, the Facility indicated it was not in full compliance with his provision, but it did report it had achieved some level of compliance in a number of component areas. Those included: specifying the actions that need to be taken by the Facility to implement the community living discharge plan under Provision T1c1; specifying the responsible Facility staff and the timeframes for the implementation of CLDP supports under Provision T1c2; review of the CLDP with the individual and LAR under Provision T1c3; the provision of a comprehensive 45-day assessment prior to transition under Provision T1d; verification of the presence of supports in the new home before transition under Provision T1e; the development and implementation of quality assurance processes under T1fl 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 T1c3, but did not find substantial compliance with the remaining provisions. The Monitoring Team noted that in many cases, the Facility relied heavily on completed monitoring tools to assess its own compliance rating. It is further noted the Facility has only recently begun using these tools and reported it is still working on inter-rater reliability. Only a small number of the instruments have been

	completed at this point. Reliance on a very small sample with an acknowledged need to strengthen inter-rater reliability may have been a factor in reaching compliance conclusions that tended to be very different from those of the Monitoring Team. In addition, the Monitoring Team urges the Facility to continue to refine and develop its own critical outcome indicators based on its own strengths, needs and experiences. **For Provision T2**, the Facility self-rated substantial compliance in T2a due to timely completion of all PMM visits and reports, high compliance scores on the Section T monitoring tools and IDT review of all PMM reports. The Monitoring Team could not substantiate compliance, largely due to serious concerns related to cross-facility PMM. This is a topic that is not covered in the monitoring tools, and again points out the need for the Facility to refine and develop its own critical outcome indicators based on its own strengths, needs and experiences and as new issues emerge. Similarly, the Monitoring Team urges the Facility to develop outcome indicators regarding the IDT review of PMM visits, based not simply on its occurrence, but also on whether it produces the desired results in terms of timely actions that support a successful transition. The Facility did not complete a self-rating in T2b, as it addresses the Monitoring Team's on-site verification of the Facility's PMM processes. Noncompliance was also found for this provision.
	Summary of Monitor's Assessment: This Section was found to be not in compliance overall. Significant deficits in the Facility's assessment processes continued to hamper these efforts to develop and implement adequate transition planning. This remained a matter of substantial concern to the Monitoring Team. **For Provision T1**, five individuals had transitioned to community living and there were sixteen active referrals. There was some progress noted in certain CLDP processes; the Monitoring Team found substantial compliance in one provision, T1c3, which addressed the review of the CLDP with the individual and LAR to facilitate their decision-making regarding supports and services needed for community living. Otherwise, the Facility was not in compliance with the rest of the provisions. DSSLC still failed to adequately assess, plan for, and implement a plan for each person's needs for education and awareness about community living options. The Monitoring Team encourages the Facility to continue to work toward development of an individualized education/awareness strategy for each individual that takes in to account his or her specific learning needs. Continuing deficits in assessments also translated to many instances in which the IDT failed to identify in each individual's ISP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, or the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences and the strategies intended to overcome such obstacles. In turn, these deficits were apparent in CLDPs that did not adequately reflect the protections, services and supports an individual would need to make a successful transition to community living. **For Provision T2**, the Facility reported it was in compliance with T2a, but the Monitoring Team did not concur with this assessment, nor did it find compliance with T2b. The Monitoring Team found that the PMM Checklists generally appeared to be completed in a timely manner and that the Post-Move Monitor generally continued to implement the PMM process in a sufficiently rigorous manner, but some gaps and

	deficits were identified during this compliance visit that could have resulted in serious consequences. The most significant concerns were related to PMM being provided for other SSLCs, a practice that DADS had virtually eliminated at one point due to the potential for gaps to occur. The Monitoring Team recognizes the time and distance challenges in the State and that it may sometimes remain expedient to provide cross-facility PMM in certain cases. If so, DADS should prescribe a careful protocol to be followed that, at the very least, requires the Post-Move Monitor participate in the CLDP and be able to provide assurances of a full understanding of the essential and nonessential supports. The protocol should also ensure that there is close communication between the two SSLCs to facilitate IDT review and recommendations.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	Policies and Procedures related to Movement to the Most Integrated Appropriate Setting: DSSLC did not report any changes to or new policies in this area since the previous compliance visit. Transition Outcomes During Last Six Months: • Community Transitions: There were five transitions to community living between September 2011 and April 2012. 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. 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, • Referrals for Community Transitions: The Facility reported that IDTs had made a total of eight referrals for community placement between September 2011 and April 2012. At the time of the site visit, DSSLC had 16 active referrals in process, according to the Community Placemen Report. This number is approximately three percent (3%) of the Facility's current population. • Pace of Transition: The Facility was not yet meeting the 180 day target for transition to occur. At least half of the 16 individuals had been referred for more than 180 days. • Adverse Outcomes Related to Transitions: There had been no significant adverse outcomes for individuals who had moved to the community in the past six months. o Returns from Community Placement: There were no returns from a community placement during this six month period. o Deaths Following Community Placement: There were no deaths of any individuals following a community placement during this six month period. o Psychiatric hospitalizations: There were no psychiatric hospitalizations	Noncompliance

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		of any individuals following a community placement during this six month period. o Emergency medical hospitalizations: There were no emergency medical hospitalizations of any individuals following a community placement during this six month period, although one individual was evaluated at an emergency room for constipation in the seven days after his move took place. No adverse outcome resulted. Actions Taken to Encourage and Assist Individuals to Move to the Most Integrated Setting: 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. Interviews with CFR staff and review of the Section T Presentation Book indicated that actions taken included: • The Director of CFR provided training to IDT members on identification of obstacles to the most integrated setting and on the Olmstead decision. • Facility IDTs continued to receive external consultation on the ISP process, including the identification of protections, supports and services needed in the most integrated setting. • IDTs received instruction as to a DADS State Office directive that each SSLC team member was expected to include in his/her assessment/evaluation a recommendation regarding the individual's appropriateness for transition to a more integrated setting, and delineation of the supports the individual would need in that setting, and had begun to implement this requirement to a certain extent. • DSSLC completed an initial analysis of obstacles to community placement and developed several action plans to address those, as further described in T1h. • The self-advocate council was presented with information on community living options at one of its meetings. There was no evidence provided that these activities were evaluated for their efficacy. The Facility should consider developing specific outcome measures related to each of the activities it undertakes for the purpose of encouraging individuals to move to the most integrated setting appropriate to their needs. Conclusion: This provision as found to be not in compliance.	

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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:	Policies and Procedures related to transition and discharge processes: The Facility reported that it had made no changes to transition and discharge policies. The Monitoring Team found many instances in which the requirements of the statewide policies were not yet being implemented as required, and these are described below.	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.	Status of Process and Training on ISP Development: Over the past six months, DSSLC had provided some additional training on topics related to ISP development, including, for example: • The Director of CFR had provided training to QDDPs and Social Workers on identification of obstacles. • The Director of CFR had provided training on the Olmstead decision and the identification of the most integrated setting to a variety of disciplines. • The State had hired consultants to provide training, and work hands-on with teams on the ISP process. The consultants had provided some training to DSSLC IDTs. Additional training continues to be needed on how to develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. It will be important to provide teams with the tools necessary to focus on individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs. Identification by the IDT of Protections, Services, and Supports That Need to be Provided in the Most Integrated Appropriate Setting: The Monitoring Team found the IDT still failed to identify in each individual's ISP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, particularly since the teams often failed to appropriately identify the most integrated setting, as further described in Provisions F1e and T1b3. The Facility often did not have an adequate basis for determining the preferences of individuals for living arrangements. As described in Provision T1b2 below, a very small proportion of individuals living at DSSLC had opportunities to tour community living options and the annual CLOIP process was not meaningful for most. The PFA, which was	Noncompliance

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		originally intended to assist teams in developing a vision for a future life, had become more of a preference assessment that was no longer completed as a part of a team meeting. The PFAs reviewed during this compliance visit provided little in the way of a visioning of an individual's ideal living arrangement. See Provisions F1b and F1c for further discussion regarding the Facility's processes for identifying and supporting individuals' preferences. These processes continued to need considerable enhancement. Preferences of LARs and families for living arrangement were more often understood and documented. The Facility was providing some opportunities for families and LARs to learn more about community options, but these were limited, as described in Provision T1b2 below, and many families were not interested in participating in them. The annual ISP process typically did not lend itself to a comfortable discussion of community living opportunities, as described in Provision F1e. There continued to be evidence that IDT members were not as familiar with community living options as they needed to be to appropriately assist in planning for the protections, services and supports in the most integrated setting. In most instances, the ISP simply identified the supports and services to be provided at the Facility and indicated the same array would be required if community living were to be considered. The lack of a well-defined vision for an individual's life typically resulted in a failure of the teams to fully imagine what the possibilities could be. Another significant deficit in the planning process was a lack of knowledge of services that could be made available, which sometimes resulted in inappropriate identification of obstacles. This is described in more detail immediately below. <u>Identification of and Plans to Overcome Obstacles to Transition:</u> DSSLC reported it gathers obstacle information through the ISP process, and then categorizing these using a list of DADS-approved obstacles. The IDTs/QDDPs had received training from the Director of CFR in the identification of obstacles during the ISP. There were some signs of progress in this area. For example, for Individual #122, the IDT identified the LAR's concerns about safety in the community as a primary obstacle and identified several action plans to address these concerns. Overall, though, the Monitoring Team found that obstacles to transition were not consistently appropriately identified or addressed. Only one of seven (14%) recent ISPs reviewed evidenced some proficiency in this regard. Examples included: • In some instances, IDT members identified as obstacles services and supports that could be provided in community settings. For Individual #511, the Nursing Assessment indicated the individual could not be served in the community due to close supervision needed for self-injurious behaviors, a need to be followed closely by psychology, and need for a wheelchair-accessible environment. All of	

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		these supports can be, and routinely are, provided in a community setting. The remaining members of the team, including the physician, OT/PT and psychologist all concluded services could be appropriately provided in the community, indicating this individual did not have unusually high needs in these areas. The ISP did not include a final IDT determination regarding living options and obstacles. • For several individuals, the dentist indicated the individual could not be served in the community due to the need for IV sedation for dental care. There was no discussion documented regarding whether any such services might be available in a community setting, or any action plan to follow up on this information. The final determination of living option for all three of these individuals was to remain at DSSLC due to LAR preference and/or behavioral needs. • For Individual #537, who indicated a desire to live in a group home, the IDT determined that a lack of awareness of community living options was one of several obstacles. The Action Plan stated in the ISP was to increase knowledge of community living options, but the action steps were 1) that the individual had past failed placements and had a PBSP, 2) that the IDT had concluded there were severe behavior problems that precluded community living, 3) that medical conditions presented a "very unsafe potential for community placement," and 4) that the individual would continue semi-monthly overnight visits to the parent's home on a contingency basis. None of these addressed the stated obstacle of lack of community awareness and no additional action plans were developed. The individual might well have had serious obstacles to community living, although it was noted the Psychology assessment indicated the individual could be served in the community with certain supports. These obstacles would not preclude his learning about community options and such learning might even be fashioned to encourage community-appropriate behaviors. <u>Conclusion:</u> This provision was found to be not in compliance. Substantial continued training is needed by the IDTs.	
	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.	<u>Provision of Adequate Education About Available Community Placements to Individuals and Their Families or Guardians to Enable Them to Make Informed Choices:</u> In December 2011, the parties met and agreed to a set of criteria for evaluation of Provision T1b2. The Monitoring Team had the following findings for each of the criteria. <u>An individualized plan for each individual (e.g., in the annual ISP):</u> The Facility did not yet succeed in developing individualized plans for community education and awareness. There was some progress observed in the sample of recent ISPs reviewed. In one impressive example, for Individual #742, the IDT developed a very personalized	Noncompliance

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		approach in working with an LAR who was reluctant regarding community living options that built on a trusting relationship between the LAR and the IDT. The plan included asking the Facility to plan a Provider Fair for the summer, when the LAR could attend, and planning a series of community home tours for the individual and LAR that the QDDP would also attend. This type of plan was the exception rather than the rule, however. More common was an example, for Individual #511, in which the IDT found the individual needed more opportunities for community exploration. The ISP stated that the individual would continue community outings and the LAR would be invited to attend a Provider Fair, but no Action Plans were developed for either of these strategies. Annual provider fair: The Facility held its most recent annual provider fair on September 9, 2011, as reported during the previous monitoring site visit. The Director of CFR indicated the Facility was considering making this a semiannual event. The Facility did measure attendance, also as previously reported in the last monitoring period. The Facility had also collected survey information from attendees, but had not yet taken any action or developed any plans in response to these data. The Director of CFR stated the Facility planned to do so. Regular SSLC meeting with Local Authorities (LAs): The Director of CFR stated his department continued to meet with the LAs (formerly known as MRAs) in the Facility's catchment area on a quarterly basis, although there was no set or formal agenda. Education about community options is evaluated for improvement: DSSLC did not have any consistent or formalized plan for collecting data on specific outcomes or measures related to education about community living, nor for using such information to evaluate opportunities to improve outcomes. Examples included: • IDT Action Plans: The Facility should consider collecting data regarding the implementation of ISP Action Plans for community awareness and education in order to ensure these receive sufficient priority by IDTs. Although IDTs are required to document progress and activity in the ISP monthly and quarterly reviews, the reality is that much of the documentation is limited to statements such as "service provided/not provided," to the extent that it is not useful in developing future community awareness strategies. • CLOIP: As indicated in previous reports, the annual LA CLOIP process continued to comprise a significant portion of the Facility's overall plan for education and awareness for individuals. The Monitoring Team reviewed a sample of 44 CLOIP Worksheets for ISPs held in the March 2012 and for ISPs being held during the week of the site visit. For 21 of the 44 (47%), the LAR did not allow the LA Service Coordinator to provide the individual with information about living options or the LA did not meet with the individual for some other reason. For only five of the 23 (22%), in which the LA did engage the individual in the CLOIP,	

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		was the LA Service Coordinator able to document the individual had any interest in or meaningful response to the materials or information being offered. This would indicate DADS needs to assess how the process, materials and/or information might be modified to more effectively meet the needs of the individuals. • Community Tours: As described further below, the Facility did not have a consistent or formal process for documenting and/or evaluating the community tour process. Tours of community providers: In the past six months, there were 30 community tours reported. There did not yet appear to be a consistent, formalized process in place at the Facility to fashion these tour as a part of an individualized community living awareness and education plan. The Director of CFR confirmed this to be the case and indicated the Facility still needed to work to make the tour experiences into a meaningful learning event. Specific findings regarding community tours included: • Opportunities to go on a tour available to all (except those individuals and/or their LARs who state that they do not want to participate in tours): There did not yet appear to be a consistent, formalized process in place at the Facility for ensuring opportunities for community tours were available to all. In the past six months, a total unduplicated count of 61 individuals participated in community tours, a number which is slightly more than ten percent (10%) of the population of the Facility. • Places chosen to visit are based on individual's specific preferences, needs, etc: An individualized education and awareness plan should define the types of settings to which an individual may need exposure to facilitate his or her understanding of community living options. There was no consistent or formalized process described for choosing tour sites based on individual preferences and needs. • Size of tours: The number of individuals attending a single tour may have a significant impact on the learning experience for the participants, as well as the ability of staff to gauge individuals' reactions and respond appropriately to facilitate learning. During the past six months, tour sizes at DSSLC ranged from one individual up to nine. Attendance documentation indicated that smaller groups were the norm, however, with only two instances noted in which the group size exceeded four individuals. • Individual's response to tours assessed: A careful and thoughtful assessment of an individual's reactions to a community tour is necessary to an understanding of personal preferences, as well as to further guide the IDT in the development of an individualized community awareness plan and of a vision for living in the most integrated setting. There was no consistent	

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		or formal process described for making an assessment of an individual's response to the tour experience unless the individual had been referred for transition planning. Opportunities are provided to visit friends who live in the community: There was no evidence provided that individuals living at the Facility had been provided with opportunities to visit friends who lived in the community. The Post-Move Monitor noted that there had been some planning for such a visit to the home of Individual #458, but this had not yet occurred. The Monitoring Team encourages the Facility to follow-up on this plan and to ensure it evaluates the experience and its learning potential for the individuals involved. Education provided in various venues: In addition to the Provider Fair and the Annual MRA Inservice described above, there was one self-advocacy meeting held during this past six months that addressed community living options. A plan for staff to learn more about community options: The Director of CFR reported there was no formal coordinated plan at this time to educate staff about community options. Some educational opportunities had been provided through staff participation in community tours and community exploration activities for individuals. During the six months since the last monitoring site visit, the Facility documented 84 staff participating in tours, although an unduplicated count indicated the actual number of staff participating was reduced to 50. Staff also have the opportunity to attend the annual LA inservice and the annual Provider Fair, but none of these had been held during this six month period. The Facility had not developed or provided any written materials for staff to inform them about community living options. Individuals and families who are reluctant have opportunities to learn about success stories: As noted in the previous monitoring report, an individual who had moved from the Facility was invited back to participate in the annual Provider Fair and turned out to be the "star of the show," with many individuals still residing at the Facility remembering her. No additional evidence was provided of such activities in the past six months. Since monitoring began, the Facility has indicated it planned to develop materials that would highlight successful transitions, but this had not yet occurred nor did it appear to have the priority it once held. Conclusion: This provision was found to be not in compliance. The Monitoring Team commends the efforts of the Facility toward promoting education and awareness. 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. IDTs continued to need additional instruction as to how to develop an individualized	

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		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 each individual.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	<u>Assessment Practices Related to Transition and Discharge:</u> The Facility reported it used the Community Living Options Discussion Record (CLODR) as the process for assessing individuals for community placement. The Community Living Options discussion was not yet implemented in such a manner that it could be considered an effective assessment for placement. 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. DADS and the Facility had undertaken some efforts to improve these processes. The new ISP format, which was in the early stages of implementation, placed additional emphasis on the living options discussion and specifically required the IDT to assess individual and LAR preferences as well as IDT recommendations in distinct sections, followed by a section entitled Living Option Determination at the conclusion of the plan. This appeared to have some promise in terms of identification of the most integrated setting appropriate to the individual's needs, a team decision that frequently was different from the actual team decision to make a referral for community living, but IDT members were not yet implementing this in an adequate manner. This is discussed in more detail in Provision F1e above. In addition, as noted in Provision F1e, IDT members were to provide a recommendation regarding the most integrated setting in their individual assessments, and this was not yet consistently occurring. Professionals did not yet consistently provide their determination regarding the appropriateness of referral for community placement in their annual assessments. As reported in Provision F1e the Monitoring Team found only (41%) of assessments provided for seven recent ISPs included such a determination. IDTs typically did not engage in an integrated discussion of how these individual opinions could be synthesized into a team decision, as described in Provision T1b1. Overall, living options for individuals were not thoroughly discussed during the annual ISP meeting <u>Percentage of Individuals Assessed as Required:</u>	Noncompliance

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		The process in use at the Facility to assess individuals for community living remained inadequate to qualify as an assessment for community placement; therefore, the Monitoring Team found that no individuals (0%) had been adequately assessed for placement. Conclusion: This provision was found to be not in compliance.	
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:	CLDP Policy and process: There were no changes reported to policies related to the CLDP. The CLDP was to be initiated at the time of referral and was to be updated on an ongoing basis as circumstances required. The APC and Transition Coordinator, who work within the Department of CFR, were responsible or coordination of the CLDP process, in collaboration with the individual's IDT. Timeliness of Development and Implementation of CLDP: Documentation indicated CLDPs were initiated upon referral. The Monitoring Team also reviewed the Community Placement Report, dated March 01, 2012. At least 50% of current referrals appeared to have exceeded the 180 days. Exploration and development of individualized community living options can be a time-consuming process and there are situations in which the 180 day timeframe will appropriately be exceeded. DAD's policy also acknowledges this and provides an avenue to apply for and receive a waiver when needed. 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 Provision T1f. It should be noted as a disclaimer that the evaluations above of these timeframes were based on the meeting dates that were listed in the Community Placement Report, which may not always accurately reflect the original referral date. The statewide database resets the meeting date to the most current ISP date when each new annual ISP data is entered; for at least one individual (#381), the time elapsed from the original referral was longer by at least one year than the Community Placement Report indicated. Development of CLDP in coordination with the LA (MRA): A review of five completed CLDPs indicated that five of five (100%) evidenced that the plan was developed in coordination with the responsible LA. In addition to the required participation in the referral meeting, the LA attended the CLDP meetings and completed the Continuity of Care-Move Site Review Instruments for the Community Living Discharge Plan as further described in T1e below. Conclusion: Overall, Provision T1c was found to be not in compliance. Coordination with the MRA in the development of the CLDP did not appear to be of significant concern at this time, but there remained concerns related to the adequacy of the CLDPs that were	Noncompliance

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		developed. Some of these concerns were related to adherence to policy, such as the identification of Facility staff to ensure each prescribed support was implemented as required. Other, weightier concerns had to do with the failure by the IDTs to adequately identify the appropriate essential and non essential supports for each individual. These deficiencies are described in more detail in Provisions T1c1, T1c2, and T1c3 below.	
	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.	<u>Identification of Essential and Non-Essential Supports:</u> The Monitoring Team reviewed documentation for five completed CLDPs. No CLDPs were held during this compliance visit. There was considerable progress noted in the process used by the CFR staff to ensure the CLDP captured the information that was contained in these assessments and in the IDT discussions held during the CLDP process, although important issues still were not adequately incorporated into the document. • For example, in the Facility's most recent CLDP for Individual #771, the Person-Directed Planning section of the CLDP indicated the individual would like to have a job and wanted to get paid. The CLDP only listed participation in day programming as a nonessential support. There were no details as to whether the day program should provide any paid work, nor any job exploration services. In addition, it was recommended by an orthotist that two pairs of good walking shoes be purchased for the individual, as referenced in the OT/PT update, but there was no indication in the CLDP as to whether these would be obtained either before or after the move. The Psychology update recommended a dental desensitization program, but the CLDP did not indicate whether this had been implemented nor did it assign responsibility for implementation. • For Individual #683, the Facility psychologist indicated in the assessment accompanying the CLDP that the individual had a Positive Behavior Support Plan (PBSP) at the Facility, but it was not recommended this would be necessary in the community. Instead, the psychologist would inservice the provider staff and then monitor the data for the first three months after the individual moved. The CLDP did not include the psychologist monitoring in the list of supports. The Monitoring Team also found the assessments and pursuant recommendations did not yet provide an adequate basis for the development of a comprehensive CLDP. 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 ISP. The IDT did appear to rely heavily on the ISP and the assessments associated with it to guide the identification of the essential and non-essential supports. The potential problem with this was that the IDTs did not demonstrate proficiency in overall needs assessment, the interdisciplinary process necessary to integrate the assessment findings	Noncompliance

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		into a comprehensive support plan, or the identification during the ISP planning meeting of the supports and services needed and desired in a community setting, as described in Provision T1b, Provision F1c, and Provision 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. Examples of poor assessment quality and the resulting negative impact on the development of a meaningful CLDP included: • Individual #771 had a visual impairment and the IDT expressed concerns throughout the CLDP community referral process as to the individual's ability to maneuver in new situations. The team did make requests of the selected provider to remove throw rugs and install a grab bar, but the OT/PT update for the CLDP made no reference to any low-vision mobility needs or strategies. • Also for Individual #771, the CLDP began with a statement that an alternate setting would provide increased opportunities for skill building and to promote independence, which were said to be important to the individual. With the exception of the Speech evaluation, the assessments did not provide any recommendations regarding skill building or independence. There were no essential and non-essential supports that referenced skill building. Instead, the CLDP indicated the individual should be afforded the opportunity to engage in activities in which she could clap her hands. The CLDP still did not consistently provide sufficient direction as to how it expected the Post-Move Monitor to adequately verify the presence or absence of supports. For example, for Individual #771, an essential support indicated the QDDP would inservice staff on habilitation therapies equipment and instructions, and indicated this would be evidenced through inservice signature sheet and by PMM observation and interview. It was not clear what information the Post-Move Monitor should be expected to glean from an interview. This was a common finding throughout the CLDPs reviewed. The Post-Move Monitor, while a QDDP and a skilled generalist in the field, cannot be expected to have discipline-specific knowledge in every case. The CLDP should, when appropriate, provide the Post-Move Monitor with the specific criteria the IDT expects as verification. This need not be an extensive narrative, but should include the essential points. If the IDT determines that discipline-specific expertise is required to adequately monitor the provision of the support, it should specify this in the CLDP. <u>Coordination of CLDP with provider staff:</u> A review of completed CLDPs indicated provider staff were very involved throughout the CLDP process. There was ample documentation of training of Provider staff and the visits by the individual to the provider sites and the individual's responses. Provider staff attended each CLDP meeting. <u>Conclusion:</u> This provision was found to be not in compliance. There was progress noted	

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		in the CLDP processes in terms of documenting individual's needs for supports and services, but this was not yet consistent. The Monitoring Team also found the assessments and pursuant recommendations did not yet provide an adequate basis for the development of a comprehensive CLDP.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	Responsible staff identified for needed actions: For zero of five (0%) of CLDPs did the Facility consistently identify Facility staff responsible for each of the essential and non-essential supports by name. In many instances, only a provider agency staff member was named. It was not clearly stated that Facility staff had any responsibility to monitor or follow up with the designated provider staff to ensure implementation and/or timeliness for each and every support. Completion timeframes for needed actions identified: For five of five (100%) completed CLDPs reviewed, the Facility did consistently identify timeframes for completion for each of the essential and non-essential supports. Conclusion: This provision was found to be not in compliance. CLDPs should identify the responsibility of the provider agency staff to actually implement certain action steps, but should also assign responsibility to Facility staff by name to ensure that all required activities are completed, even if a provider or LA staff has primary responsibility for the activity. The implementation of the Facility Pre-Move Site Visit may provide an avenue for designating the responsibility of Facility staff, as the APC could take responsibility for ensuring the completion of essential supports and plans for non-essential supports at the time of the Pre-Move Site Visit.	Noncompliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Review of CLDP with Individual and, as appropriate, the LAR: The Facility was to be commended for the progress it had made in ensuring the CLDP was reviewed with the individual and LAR as appropriate on an ongoing basis, and that this review was thoroughly documented. The Monitoring Team reviewed the documentation for five completed CLDPs and five CLDPs in process, for a total of nine, to assess compliance with this provision. For nine of nine (100%), there was ample documentation of the level of involvement by the individual and/or the LAR in the decision-making process. Conclusion: This provision was found to be in substantial compliance.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive	Timeliness of Assessments: The APC and Transition Coordinator had a process in place to review assessments and make assignments for any updates or revisions that needed to be made to an individual's current assessments. This was a positive practice that should be continued. The final	Noncompliance

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	assessment of needs and supports within 45 days prior to the individual's leaving.	assessments were then reviewed as a part of the CLDP meeting. These processes in themselves appeared to be adequate for purposes of ensuring that assessments were available and current within 45 days prior to the individual leaving the Facility. DSSLC needed to focus its attention on whether these assessments were adequately prepared, as described in Provision T1c1 and below. <u>Adequacy and Comprehensiveness of Assessments:</u> Assessments were still 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 IDT and the community provider would need to develop an appropriate transition plan. As described in Provision T1c1 above, in a review of five completed CLDPs, the Monitoring Team found that the assessments did not consistently address the services and supports needed each an individual to make a successful transition, nor how the individual's preferences could be accommodated and supported in a community setting. In addition, none of the assessments reviewed placed any emphasis on recommendations and strategies for community integration and how the individual could be supported to take advantage of the new opportunities community living might offer. <u>Conclusion:</u> This provision was found to be not in compliance. Facility action must address the adequacy of assessment practices overall before compliance can be achieved under this provision.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such	<u>MRA Continuity of Care Process:</u> The Monitoring Team reviewed the MRA Continuity of Care Pre.-Move Site Review Instruments completed for five of five (100%) individuals who had transitioned in the past six months. Each was completed within the required timeframe and included the required DADS QRS report as an attachment. None of the instruments indicated any issues that required follow-up <u>Pre-Move Site Visit Completed by Facility:</u> The APC and/or the Placement Coordinator were designated as the responsible Facility staff for completion of the Pre-Move Site Visit. No such visits were conducted during the monitoring visit, so the Monitoring Team was not able to observe the process but rather relied upon documentation to assess compliance. The Monitoring Team reviewed the Pre-Move Site Review documentation completed for five of five (100%) individuals who had transitioned in the past six months. Each appeared to have been completed in a timely manner and included a visit to each service provision site. Each essential support was verified as being in place. If this could not be verified at the initial Pre-Move Site	Noncompliance

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	supports shall be obtained by the Facility before the individual's departure from the Facility.	Visit, the CFR staff made a second trip before the transition occurred to ensure availability and adequacy. CFR staff also documented plans for non-essential supports. Conclusion: This provision was found to be not in compliance. The Pre-Move Site Visit completed by the Facility provided an important vehicle for assuring that supports were in place, or that adequate plans had been made for those non-essential supports, in a much more detailed way than the MRA Continuity of Care process. The Pre-Move Site Visits reviewed had appeared to be carefully completed. The Monitoring Team would recommend only that CFR staff maintain a comprehensive evidence documentation file in the same manner as the PMM file. This provision also relies on supports having been adequately identified in the CLDP comprehensive assessments and the Monitoring team did not find this to be the case, as further described under Provisions T1c1 and T1d, resulting in a finding of noncompliance.	
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.	Quality Assurance Processes to Ensure Development of CLDPs: DSSLC had implemented some quality assurance processes in this area. Examples included: • The CFR Department had a tracking mechanism for the 45 day assessments and a process for departmental review prior to the CLDP meeting. • CFR staff also met weekly in a placement status meeting to review referrals, status of CLDPs and other transition activities, including Post-Move Monitoring. • CFR staff met weekly with a member of the Quality Assurance staff. • The Facility had, for a brief period, implemented a community placement medical review in which a Facility physician other than the primary physician reviewed the individual's medical record and provided comments and recommendations. This process served a function much like that of the Monitoring Team's CLDP review of an individual's status in previous site visits, in that it routinely found health care issues that required exploration and/or follow-up. Unfortunately, the physician who performed these reviews was no longer available and the process had been discontinued. The Facility should consider possibilities for re-instituting this process as soon as possible, perhaps as a part of an overall peer review. Quality Assurance Processes to Ensure Implementation of CLDPs: The placement status and QA meetings described above also functioned as quality assurance processes for the implementation of CLDPs. The Pre-Move Site Review conducted by CFR staff also provided an additional layer of scrutiny to ensure that essential supports were in place prior to an individual leaving the Facility. The Monitoring Team commended this initiative, as the existing LA pre-move site visit did not focus heavily on ensuring specific supports were in place. As described under	Noncompliance

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		Provision T1e above, the Facility's implementation of the Pre-Move Site Review was adequately documented, although improvements are recommended by the Monitoring Team. Trends and Improvement Actions: The Facility's QA Department reported it had begun completing Section T Monitoring Tools in January/February 2012, but that the current emphasis was on inter-rater reliability. The Monitoring Team notes that the Facility self-rated itself to be in substantial compliance in several provisions related to the CLDP based in part on achieving 100% compliance in the completed monitoring tools, but the Monitoring Team's review had very different findings. In addition to continuing to strengthen inter-rater reliability, the Facility may need to better define the specific outcomes it must meet to achieve a compliant level. Conclusion: This provision was found to be not in compliance. The Facility had initiated some actions toward developing quality assurance processes. This was a positive step. It is recommended that clear performance goals and outcome measures be defined, along with appropriate methodology for obtaining the data. DSSLC should also ensure these are coordinated with quality assurance measures that address the overall quality of assessments at the Facility.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the	Obstacle Information Gathered: DSSLC reported it began data collection on obstacle information on April 18, 2011 through the ISP process, using a list of DADS-approved obstacles, as described in Provision T1b1. The IDTs/QDDPs had received training in the identification of obstacles during the ISP. Annual Obstacle Analysis by Facility: The Facility had produced an assessment report regarding these obstacles, with data through July 2011, entitled *Annual Report: Obstacles to Transition Denton State Supported Living Center, Fiscal Year 2011*. The report focused on obstacles to referrals for transition to community living and developed some action plans to address these. • The report noted that DSSLC serves a significant number of individuals who have LARs and that most of these are resistant to transition. The report further indicated this accounted for 103 of the 145 obstacles the Facility had documented. No action plan was indicated to address this obstacle. • The second highest category of obstacles was individual reluctance for community placement and most of this was attributed to a lack of understanding of community options. The Annual Report indicated the Department of CFR would work jointly with IDTs to develop individual action plans for obstacles	Noncompliance

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	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.	related to lack of understanding and would contact the QDDP for each of the individuals to arrange meetings to ensure effective actions were in place. There was no evidence provided that this had been accomplished. DSSLC should both develop appropriate action plans to address the significant obstacles identified in its report, as well as ensure it implements each of these as planned. <u>Appropriate Steps Taken by DADS to Overcome or Reduce Identified Obstacles:</u> DADS took steps to overcome or reduce these obstacles. • DADS created a report summarizing obstacles across the state and included the Facility's report as an addendum/attachment to the report. The statewide report was dated October 2011. • The statewide report listed the 13 obstacle areas used in FY11. DADS will be improving the way it categorizes and collects (and the way it has the facilities collect) data regarding obstacles. • DADS indicated actions that it would take to overcome or reduce these obstacles o Eleven numbered items were listed. Five were related to the IDT process and upcoming changes to this process, three were related to working with local authorities and local agencies, two were related to improving provider capacity and competence, and two were related to funding initiatives regarding slot availability and the new community living specialist positions. In general, these were descriptions of the early steps of activities related to addressing obstacles to each individual living in the most integrated setting. o DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). <u>Conclusion:</u> This provision was found to be not in compliance, although activities at the facility and state levels demonstrated progress towards substantial compliance with this provision item. Improvements in data collection and analysis, implementation of new ISP processes, and actualization of the planned activities to overcome or reduce obstacles will be necessary for substantial compliance to be obtained.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report	<u>Issuance of Report:</u> The Facility issued a Community Placement Report on Thursday, March 01, 2012, covering the period of 9/2/2011-3/1/2012. The report was issued in a timely manner. <u>Required Reporting Categories:</u> The report was in the standardized format as prescribed by DADS State Office. During	Noncompliance

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	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.	December 2010, the Monitoring Teams requested some information regarding transition be added to the reports in order to capture categories of individuals who had either requested community transition, or whose teams had determined they could be appropriately placed in the community. The State worked with the Monitoring Panel to add categories to the Community Placement Report template each of the Facilities uses, including Individual Prefers Community, Not Referred – LAR Choice; Individual Prefers Community, Not Referred – Other Reasons; and LAR Prefers Community, Not Referred, and these are included in this report: • Four community placements • Sixteen current referrals • Two rescinded referrals • No individuals who preferred community, not referred-LAR choice • Two individuals who preferred community, not referred-other reason • No individuals for whom the LAR prefers community, not referred. <u>Reporting on Individuals not referred due to LAR choice:</u> The Monitoring Teams also asked that a final category be added that includes a list of names of individuals who would be referred by the IDT except for the objection of the LAR, whether or not the individual himself or herself has expressed, or is capable of expressing, a preference for referral. As noted above with regard to Provision T.1.a, professionals on individuals' teams need to make independent recommendations regarding the appropriateness of an individual for community placement. The State indicated that at this time, its data system did not include this information, but it was working toward being able to produce the data the Monitoring Panel requested. It was not clear that the data provided in this category was accurate, as it did not appear to fairly represent the scope of LAR choice in a team decision not to make a referral. While the Community Placement Report listed no individuals who preferred community but were not referred due to LAR choice, DSSLC's annual obstacles report lists seven such individuals in *Table 4: Individuals not recommended for movement that prefer to reside in the community from the Denton State Supported Living Center, FY 2011.* The Facility also provided the Monitoring Team another list of individuals not referred due to LAR preference in response to the document request that listed 244 individuals. The Monitoring Team also observed during this site review that IDTs continued to find no barriers to community living, yet decided DSSLC was the most integrated setting based on the LARs' preferences. The Monitoring Team looks forward to reviewing data that provides an accurate picture in this area in the future. <u>Conclusion:</u> This provision was found to be not in compliance. The report was made in a timely fashion but the Monitoring Team notes its concern related to the accuracy of some of the data and encourages DADS and the Facility to examine these issues.	

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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.	Policies and Procedures related to Post-Move Monitoring: The Facility reported there had been no changes or additions to policies related to Post-Move Monitoring. Staffing: The current level of staffing appeared to be adequate to the PMM workload. The Post-Move Monitor continued to provide some PMM services for other SSLCs. This was not consistent with a stated DADS informal policy that SSLCs must provide their own monitoring, a decision that had been made after some gaps were found in cross-facility PMM processes in the past. The Monitoring Team reviewed PMM Checklists for 12 individuals who had moved to the community and interviewed the Director of CFR and Post-Move Monitor. The Monitoring Team assessed both timeliness of the PMM visits and the use of the standardized tool for completing the assessment for the presence of CLDP-prescribed supports. Findings included: Timeliness of Post-Move Monitoring Visits: The Monitoring Team found that the PMM Checklists were being completed in a timely manner in most cases. Each of the 7, 45 and 90-day PMM visits (100%)were made within the required timeframes. Use of Standard Assessment Tool: In each case, the PMM visits were documented using the prescribed standardized tool, the Post-Move Monitoring Checklist as revised in May 2011. Assessment of Presence of Supports Called for in CLDP: For the most part, the PMM Checklists reviewed during this compliance visit continued to provide in-depth information that painted a picture of the individual's adjustment. In most instances, 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 generally had taken actions and maintained a comprehensive record of emails and phone logs that documented careful follow-up and loop closure. There were some deficiencies noted, however. The most significant concerns were related to PMM being provided for other SSLCs:	Noncompliance

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		• In a serious example, the Post-Move Monitor had participated in the CLDP for an individual from another SSLC, but did not have any prior knowledge of the individual's needs. Individual #266 had a history and diagnosis that indicated a high risk for offending behaviors. The CLDP did not adequately address the individual's needs for ongoing treatment nor appropriate risk strategies. One essential support called for the provider to execute a pass agreement with the family for those times when the individual visited the family home. No details were provided as to what the pass agreement should include. A PMM visit was made to the individual's home during the 7-day review, and a copy of the pass was obtained, but it failed to adequately address the safeguards needed given the high risk posed. The Post-Move Monitor documented only that the pass had been developed and visits were to be scheduled to the family home. Another PMM visit was made during this compliance visit in which no additional scrutiny was given to this issue, even though the individual was scheduled to make a visit to the family home that following weekend without adequate supervision from the provider. t. DADS and the Facility acted to immediately ensure these issues were addressed when brought to their attention by the Monitoring Team, but without that intervention, the PMM process would have documented a paper compliance while a significant risk still remained. The DSSLC Post-Move Monitor could not fully be held accountable for the CLDP designed by another facility, but she did acknowledge she did not feel completely comfortable with how some of the supports were described nor what she should be looking for to verify implementation. It does remain incumbent on the Post-Move Monitor to assure herself of a thorough understanding of the individual's needs when responsibility for the monitoring is accepted. • In another instance, the request for DSSLC to provide PMM services was not made until the day before Individual #124 was to move. This made it impossible for the DSSLC Post-Move Monitor to participate in the CLDP or to otherwise prepare to be fully aware of the individual's needs. Such preparation is perhaps even more critical when the individual is from another facility and the Post-Move Monitor has no prior knowledge of his or her needs. These cases highlight the concerns that originally led DADS to decide that all PMM should be accomplished by the sending Facility; however, the Monitoring Team recognizes the time and distance challenges in the State and that it may sometimes remain expedient to provide cross-facility PMM in certain cases. If so, DADS should prescribe a careful protocol to be followed that, at the very least, requires the Post-Move Monitor participate in the CLDP and be able to provide assurances of a full understanding of the essential and nonessential supports. The protocol should also ensure that there is close communication between the two SSLCs to facilitate IDT review and recommendations.	

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		Facility's Efforts to Ensure Supports are Implemented: The Facility kept excellent documentation of efforts to ensure supports were implemented. The Post Move Monitor continued to make many notes and maintained a file with materials she collected to verify the implementation of supports as well as to document follow-up. The Monitoring Team commends the work of the Post Move Monitor for this process of maintaining complete documentation. There were a few instances in which the Facility did not document adequate follow-up action to ensure supports were implemented. • In one such example, for Individual #384, the Post-Move Monitor noted during the 45-Day review that staff at the individual's home did not seem aware of the prescribed seating needs until direction was provided by the Post Move Monitor. There was no documentation of any follow-up to ensure training was current and/or repeated as needed. • For Individual #634, the Post Move Monitor documented ongoing and frequent follow-up action between the 7-Day and 45-Day reviews to encourage the provider to complete a pica checklist that was to be used on a daily basis. The Monitoring Team commends the diligence of the Post-Move Monitor; however, the Post-Move Monitor identified the lack of implementation of this essential support on 7-29-11 and it was not satisfactorily resolved until 9-8-11. This was much too long a period for a support so essential to health and safety to be not in place. The Post-Move Monitor should notify the IDT when she is unable to effect a timely resolution for any essential support. In this case, the individual was from another SSLC, which may have affected the ease with which contact with the IDT could be made. This reinforces the need to include IDT review processes in any cross-facility PMM protocol. Barriers to thorough PMM Review and Improvements Needed in Monitoring: • A protocol is needed if DADS continues to find it necessary to allow cross-facility PMM. • DSSLC kept good documentation of IDT review of the PMM Checklists, but it was noted that several weeks typically elapsed between the PMM visits and the review by the team. • The IDTs still 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 IDTs continued to indicate the evidence required to verify essential supports related to training were to be only a training roster. The IDT should clearly state the necessity to interview and observe for staff compliance and knowledge in addition to the paper review of a training roster.	

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		Conclusion: This provision was found to be not in compliance. The PMM process was typically implemented in a diligent manner, but some gaps and deficits were identified during this compliance visit that could have resulted in serious consequences.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	Observation of Post-Move Monitoring Visit: The Monitoring Team accompanied the Post-Move Monitor on a PMM visit for Individual #458. Both the day program and residence were visited. A review of the previously completed PMM Checklists indicated visits had been made to all required environments in each of the 7 and 45-Day visits. The individual appeared to have adjusted well to both the home and day program environments. Services and supports appeared to be provided as called for in the CLDP. Staff in both environments were knowledgeable of the individual's needs and preferences and it appeared the relationships between staff and the individual were respectful and supportive. The Post-Move Monitor continued to demonstrate diligence in this on-site review. She ensured the presence of all essential supports and the status of all nonessential supports through an appropriate combination of document review, direct observation, staff interview, and interview and interaction with the individual. The Post-Move Monitor used the previous PMM Checklist to ensure follow-up from earlier visits was completed. She obtained, or made arrangements to obtain, needed documentation. It was clear she was very knowledgeable of the individual's needs and preferences and had excellent rapport with the individual. Conclusion: While the Monitoring Team found no deficiencies in the monitoring process during this particular PMM visit, there was a significant concern regarding another PMM visit that took place during the monitoring site visit for Individual #266, as described in T2a. The Monitoring Team did not accompany the Post-Move Monitor on this visit, but became aware of the deficiency shortly after the PMM visit was completed. Given the seriousness of the potential harm that could have resulted from the failure to ensure the adequacy of the implementation of an essential support, this provision was found to be not in compliance.	Noncompliance
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		

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	period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day 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	Number and Categories of Alternate Discharges: The Facility reported two Alternate Discharges during the past six months. Both were for individuals who moved to other SSLCs within the state. Compliance with CMS-required Discharge Planning Procedures: The Monitoring Team reviewed the discharge packets for both individuals for consistency 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. For Individual #657, the discharge appeared to have been completed in a compliant manner, and provided a thorough assessment of the individual's status. For Individual #374, very little information was provided with the discharge summary. Instead it was noted that assessments would be completed when the individual was admitted to the other SSLC. There were extenuating circumstances, in that the individual had been hospitalized in another treatment facility since 2009, so that it could not be expected that DSSLC staff could provide current status assessments. However, it must be assumed that the treatment facility in which the individual was residing could provide these assessments. As the responsible SSLC, the Facility should have attempted to obtain these in the process of developing the discharge packet. Particularly given the severe nature of the individual's mental health needs that had necessitated hospitalization for such an extended period, it would be incumbent upon DSSLC to make every effort to ensure the receiving facility had ample and current assessment information. Conclusion: This provision was found to be not in compliance.	Noncompliance

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	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 Facility should refine and develop its own critical outcome indicators based on its own strengths, needs and experiences and as new issues emerge. (Self-Assessment)
2. The Facility should develop outcome indicators regarding the IDT review of PMM visits, based not simply on its occurrence, but also on whether it produces the desired results in terms of timely actions that support a successful transition. (Self-Assessment)
3. The Facility should consider developing specific outcome measures related to each of the activities it undertakes for the purpose of encouraging individuals to move to the most integrated setting appropriate to their needs. (Provision T1a)
4. 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 T1c)
5. The CLDP should, when appropriate, provide the Post-Move Monitor with the specific criteria the IDT expects as verification of essential and non-essential supports. If the IDT determines that discipline-specific expertise is required to adequately monitor the provision of the support, it should specify this in the CLDP. (Provision T1c1)
6. CFR staff should consider maintaining a comprehensive evidence documentation file in the same manner as the PMM file. (Provision T1e)
7. The Facility should consider possibilities for re-instituting the community placement medical review process as soon as possible, perhaps as a part of an overall peer review. (Provision T1f)
8. In addition to continuing to strengthen inter-rater reliability in the use of monitoring tools related to the CLDP, the Facility may need to better define the specific outcomes it must meet to achieve a compliant level. (Provision T1f, Facility Self-Assessment)
9. DSSLC should both develop appropriate action plans to address the significant obstacles identified in its Annual Report, and ensure it implements each of these as planned. (Provision T1g)
10. DADS and the Facility should examine issues related to the accuracy of data related to LAR choice and referrals for community living as reported in its Community Placement Report. (Provision T1h)
11. The Post-Move Monitor should notify the IDT when unable to effect a timely resolution for any support. (Provision T2a)
12. A protocol should be developed if DADS continues to find it necessary to allow cross-facility PMM. It should prescribe a careful protocol to be followed that, at the very least, requires the Post-Move Monitor participate in the CLDP and be able to provide assurances of a full understanding of the essential and nonessential supports. The protocol should also ensure that there is close communication between the two SSLCs to facilitate IDT review and recommendations. (Provision T2a)

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 42. Denton State Supported Living Center (DSSLC) Self-Assessment, updated 3/16/2012 43. Denton State Supported Living Center Action Plans, updated 3/18/2012 44. Denton State Supported Living Center Report for Monitors, dated April 2, 2012 45. Section U Presentation Book materials 46. DADS Policy 019: Guardianship, effective 3/7/2012 47. DSSLC Policy CMGT 30: Guardianship, dated January 16, 2012 48. DSSLC Policy CMGT 27: Affirming and Protecting Rights, effective 01/20/2012 49. DSSLC Policy CMGT 04: Legal Consent, dated June 1, 2006 50. DSSLC Policy CMGT 27J: Right to Autonomy, dated February 24, 2011 51. Rights Assessment, Form 6614, dated September 2011 52. Completed Rights Assessments for Individuals #1, #121, #239, #306, #362, #383, #395, and #499 53. Human Rights Committee (HRC) Minutes for the week of April 2, 2012 54. Guardianship Committee Minutes for the past six months 55. Self-Advocacy Minutes for the past six months 56. The most recent prioritized list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and a LAR to render such a decision. 57. Since the last review, a list of individuals for whom an LAR or advocate has been obtained 58. Over the six (6) months preceding the monitoring visit, documentation that reflects the activities of the facility to obtain LARs or advocates 59. QA/QI Council Meeting: Data Analysis Report, Sections F. R, S, T, U, V and M, dated February 21, 2012 **People Interviewed:** 1. Pam Garrett and Sezer Ruzek, Human Rights Officers (HROs) 2. Lori Powell, Director of Quality Assurance **Meeting Attended/Observations:** 6. ISPs for three Individuals: Individuals #1, #53, and #464 7. Guardianship Committee
	Facility Self-Assessment: The Monitoring Team reviewed the DSSLC Self-Assessment for Section U. The current Self-Assessment reported on the activities engaged in to conduct the self-assessment, provided its assessment of the results of the self-assessment and finally provided a self-rating stating why or why not it believed compliance had been achieved. The Monitoring Team would recommend the Facility consider specific measurable outcome indicators to be reviewed in addition to the fairly subjective process measures in the current Self-Assessment. This might include, for example, competency measures related to the many commendable training efforts that have been initiated in this area. **For Provision U1 and Provision U2**, the Facility indicated it was not yet in compliance and the Monitoring Team concurred. The Facility indicated in both cases that its processes were very new and not yet firmly established. It also indicated it would need to engage in considerably more staff training.

	Summary of Monitor's Assessment: This Section was not yet in compliance, but the Monitoring Team commends the Facility for considerable progress made over the past six months in policy development and staff training, as described below. **Provision U1:** This provision was found to be not yet in compliance. DADS State Office had issued a new policy, DADS Policy 019: Guardianship, effective 3/7/2012, with five Exhibits, that provided some guidance to the Facility in the development and maintenance of 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. The Monitoring Team remained concerned that the new policy, while requiring IDTs to make an assessment of an individual's decisional capacities, provided little to no guidance as to how this assessment should be accomplished. The policy did not address the standardized tools or methodology IDTs should use to assess and prioritize the need for an LAR, an advocate or other assistance an individual might need in decision-making. DSSLC had taken a number of actions in the past six months to implement the requirements of this provision, with much progress noted. The Facility had localized DADS Policy 019 in DSSLC Policy CMGT 30: Guardianship, dated January 16, 2012. The local policy had a number of modifications from the new statewide policy, and most seemed to be internally consistent with the DADS document. The Facility maintained 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, using criteria that were tied to its Integrated Risk Rating data. This was a creative approach to attempting to obtain objective and individualized information on which to base these decisions. The HROs also worked with the DSSLC IT staff to populate the Priority List with the risk rating data on an ongoing basis. As a result, it could be updated in real-time, rather than just semi-annually. The Monitoring Team commends the creativity and initiative of the Facility in this regard. DSSLC had also very recently begun to pilot a new expanded Rights Assessment, as provided for under its DSSLC Policy CMGT 27: Affirming and Protecting Rights, effective 01/20/2012. The HROs had provided training on the use of this new tool to QDDPs in a pilot area and had worked with IDTs in these areas to complete six of the new Rights Assessment as of the time of the compliance visit. There was evidence that the Rights Assessments completed with the assistance of the HROs contained a more thoughtful and thorough approach to assessing an individual's needs in the area of decision-making and addressing them in ISP Action Plans. The HRC review of these assessments had also become more rigorous. The Monitoring Team would encourage DADS and the Facility to construct an evaluation plan to measure the outcomes of this pilot process, both in terms of the tool and in the process teams use to complete it. **Provision U2:** This Provision was found to be not in compliance. As part of the Facility undertaking an effective and appropriate large-scale effort to solicit guardians, it still needs to ensure it has an appropriate methodology in place to determine the actual need for guardianship. As this is being developed, the Facility was to be commended for its significant efforts toward developing a variety of supports for individuals who require some level of assistance in making decisions, such that guardianship was not the only option.

	DSSLC had localized DADS Policy 019 in DSSLC Policy CMGT 30: Guardianship, dated January 16, 2012. The Facility had established a Guardianship Committee that been meeting regularly since September 2011. Its responsibilities had been spelled out, but it was not yet clear the members had a full understanding of what actions they were expected to take. The HROs had attended 24 ISP meetings to provide technical assistance and consultation to teams on guardianship and rights assessment issues and had focused much effort on staff training. The Monitoring Team looks forward to seeing all aspects of support for decision-making and informed consent in full operation at the time of the next site visit.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking 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.	<u>Policies and Procedures related to functional capacity to give consent and/nor need for LAR</u> DADS State Office had issued a new policy DADS Policy 019: Guardianship, effective 3/7/2012, with five Exhibits. The stated purpose of this new policy was "…to ensure that individuals residing in State Supported Living Centers (SSLCs) and their legally authorized representatives (LARs) and correspondents are made aware of guardianship services available in Texas and to identify those individuals without a LAR who would benefit from having an LAR to help them make decisions regarding treatment and programming." The draft policy did not provide substantial guidance to the Facilities and the IDTs in how to assess an individual's decisional capacities and/or need for guardianship. No standardized tool or process was described for IDTs to use in making these determinations. Rather, the policy stated "… (T)he IDT discusses the individual decisions-making abilities and guardianship need at the annual IDT meeting for each individual residing in the State Center." In Exhibit A: Procedures, the only guidance to the Facility is that the IDT will review the individual's capacity to make decisions regarding his or her health and welfare at the annual meeting Policy 019 did address other requirements pertinent to Provision U1, including the development and maintenance of a prioritized guardianship list. The policy stated that the "IDT" would prioritize the guardianship list, but also assigns responsibility for "developing, prioritizing and maintaining" the list to a Guardianship Committee. Exhibit A: Procedures also indicated it would be the responsibility of the Committee to make the prioritization. DADS should clarify its intent. The prioritization criteria contained in DADS Policy 019 were identical to the requirements in the SA, 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	Noncompliance

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		medications; and those with potential guardianship resources. The policy indicated that individuals would be assigned to one of three priority levels, depending on the number of factors that pertained to them. Priority I was to be assigned to individuals who met three of four criteria, Priority II to those who met two of four and Priority III to those who met one of four. Exhibit A: Procedures calls for the Guardianship Committee to consider the following criteria: whether the individual has an actively involved person to advocate for him or her; a pattern of injury, abuse or neglect; receives or is proposed to receive a restrictive program; receives psychoactive medication; has serious, ongoing medical needs; and/or has severely impaired communication. It was not clear how these two sets of criteria were meant to be integrated. The Monitoring Team remained concerned that the new policy, while requiring IDTs to make an assessment of an individual's decisional capacities, provided little to no guidance as to how this assessment should be accomplished. The policy did not address the standardized tools or methodology IDTs should use to assess and prioritize the need for an LAR, an advocate, or other assistance an individual might need in decision-making. The Facility's IDTs continued to need guidance and 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. It was reported that a workgroup continued to work toward developing such guidance, and a new draft Rights Assessment was being piloted at DSSLC, but there was no known projected date for formal issuance of an approved Rights Assessment document from DADS. Since the guardianship policy requires the teams to make this capacity determination, it would seem to be essential that the guidance be provided at the same time the guardianship policy is implemented. Otherwise, the Facility runs the risk of inappropriately identifying need for guardianship that, if acted upon, could result in an individual unnecessarily losing rights to make and/or participate in his or her own decisions. The statewide policy also called for the HRO to maintain data, including a list of individuals without an LAR; names and priority levels of individuals referred to the Guardianship Committee; status of the referrals; and dates guardianships were secured. These data were to be entered into a DADS statewide database. In addition, the Facility was to make monthly progress notes regarding the status of individuals referred to the Guardianship Committee. DSSLC had localized DADS Policy 019 in DSSLC Policy CMGT 30: Guardianship, dated January 16, 2012. The local policy had a number of modifications from the new statewide policy, and most seemed to be internally consistent with the DADS document; however, the Facility may want to review the local policy to ensure it comports fully with	

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		the newly issued Policy 019. A major modification contained within DSSLC Policy CMGT 30: Guardianship was the prioritization protocol. DSSLC created a methodology for using the results of the Facility's Integrated Risk Rating process to more fully inform the broader criteria in the statewide policy, such as the comparatively frequent need for decisions requiring consent and the comparatively most restrictive programming. This appeared to be both consistent with and an improvement upon the guidance in the statewide policy, but DSSLC should confirm with DADS that this is an acceptable modification, particularly since it may impact statewide data analysis. This local process is further described below. The Facility had also promulgated DSSLC Policy CMGT 27: Affirming and Protecting Rights, effective 01/20/2012. Exhibit A to the policy was a Rights Assessment document, Form 6614, dated September 2011, which included an expanded section for assessing an individual's ability to provide informed consent. The policy and exhibits did not include instructions for staff as to how to implement the expanded Rights Assessment, but the HROs had recently begun providing training to IDTs in the process. <u>Maintenance of Prioritized List</u> The Facility maintained a prioritized list. It used prioritization criteria that were tied to its Integrated Risk Rating (IRR) data. These data provided an individualized assessment by each IDT of risk factors that would support determinations that individuals had comparatively frequent need for decisions requiring consent and/or comparatively most restrictive programming. This was a creative approach to attempting to obtain objective and individualized information on which to base these decisions. As the IDTs improve their abilities in evaluating risk in the IRR process, these data will likely become more reliable for use in the prioritization process. The HROs also worked with the DSSLC IT staff to populate the Priority List with the IRR data on an ongoing basis. As a result, it could be updated in real-time, rather than just semi-annually. The IRR data were supplemented by information from the Rights Assessment concerning an individual's ability to provide informed consent and information about potential guardianship resources. The Monitoring Team commends the creativity and initiative of the Facility in this regard. This list had also been merged with the list of individuals' current guardianship status. This allowed the Facility to have a single master database regarding guardianship. The Monitoring Team reviewed the Priority List provided in the Section U Presentation Book, dated March, 2012. There were 174 names on the list. Individuals were ranked on a priority scale from one (least in need) to twelve (most in need). As noted previously, DSSLC should consider how it will reconcile these twelve categories with the requirements to report in three categories (Priority I, II and III) to the State Office. It was again observed that this list would be updated in real time as IRR and Rights Assessment	

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		data were received. The Facility also further broke down its list by creating a "Preliminary Priority List" of the ten individuals who had the highest need rankings and chose to focus much of their efforts to obtain LARs on these individuals. During the review of the process for developing the list, it became apparent it could also be used to identify individuals who had been adjudicated incompetent, but who no longer had an LAR due to the incumbent's death or other inability to continue to serve, and for whom a successor guardian had not been named. The Monitoring Team recommended the HROs use this list to identify those individuals who had been, and seemed likely to remain, without a guardian for a lengthy period and to consider how this status might factor into the prioritization. <u>Assessment of Functional Capacity to Render a Decision</u> The Facility had not routinely used standardized or valid instruments and/or processes to assess functional capacity, so the decision to place someone on the prioritized list was still without a sound basis for the most part. DSSLC had, however, recently begun to pilot a new expanded Rights Assessment, as provided for under DSSLC Policy CMGT 27: Affirming and Protecting Rights, effective 01/20/2012. The HROs had provided training on the use of this new tool to QDDPs in the pilot area and had worked with IDTs in these areas to complete six of the new Rights Assessment as of the time of the compliance visit. The Monitoring Team reviewed these six, as well as two that were developed at ISP meetings during this site visit within the pilot area. There was evidence that the Rights Assessments completed with the assistance of the HROs contained a more thoughtful approach to assessing an individual's discrete needs and abilities in the area of decision-making and, in some instances, addressing them in ISP Action Plans. For the one that was developed within the pilot area, but without the hands-on assistance of the HROs, the Monitoring Team did not note the same level of careful scrutiny. This would indicate additional training and mentoring was needed, as the Facility recognized in its self-assessment. While it may prove to be useful, the draft Rights Assessment in use in the pilot is not a currently accepted standardized tool for assessing decisional capacity. The Monitoring Team would encourage DADS and the Facility to construct an evaluation plan to measure the outcomes of this pilot process, both in terms of the tool and in the process teams use to complete it. The Monitoring Team looks forward to reviewing the progress in this area at the next compliance visit. The HRC review of the informed consent assessments had also become somewhat more rigorous. The Monitoring Team reviewed minutes of the HRC meeting that was held during the week of the compliance visit and found it was more clearly individualized than in the past. The HRC questioned the team representative in more depth as to the	

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		assessment and IDT deliberation processes. It also required more evidence of ISP strategies to enhance decision-making capacity that were relevant to individuals' identified needs in the informed consent areas. This new process held promise, in concert with other strategies described herein, for guiding IDTs toward providing more training and support for individuals' decision-making capacities. <u>Conclusion:</u> This Provision was found to be not yet in compliance. The Facility did maintain a list of individuals it deemed to be in need of a guardian that was updated regularly and was prioritized according to a novel internal protocol that drew from the IRR process. The Facility had also very recently begun piloting an expanded Rights Assessments, but much staff training as well as an evaluation of the instrument's application as a standardized tool for assessing decisional capacity remained to be accomplished.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	<u>Policies and Procedures related to obtaining LARs for individuals in need</u> DADS Policy 019: Guardianship, effective 3/7/2012, also provided guidance and protocol as to obtaining LARs for individuals who may need one. The Policy designated the Facility HRO to act as the Guardianship Coordinator. Specific duties of the Guardianship Coordinator include the following: • Establishing a Guardianship Committee that meets regularly to discuss guardianship needs at the State Center; • Working with the QDDP Coordinator and QDDPs to develop and maintain a prioritized guardianship list of individuals in need of a guardian; • Providing information to the State Center's Parent/Family Association members regarding alternatives to guardianship and local guardianship programs and resources; • Sharing appropriate information regarding individuals in need of a guardian with local guardianship programs as permitted by law; • Soliciting information from local guardianship programs regarding community supports available to assist with guardianship fees, court costs, and other expenses; and, • Organizing an annual guardianship in-service for individuals, families, staff and other interested parties to discuss guardianship, alternatives to guardianship, the benefits and disadvantages of guardianship, limitations to guardianship, types of guardianship, who can and cannot be a guardian, and other relevant topics. The Policy also required the Facility to develop a Guardianship Committee. According to the policy, the Guardianship Committee is responsible for developing, prioritizing and maintaining the prioritized list as described in Provision U1. Other responsibilities or	Noncompliance

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		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. DSSLC had localized DADS Policy 019 in DSSLC Policy CMGT 30: Guardianship, dated January 16, 2012, as described in Provision U1. There were no significant differences from the statewide policy as they related to the roles and responsibilities of the Guardianship Coordinator and the Guardianship Committee, although the local policy did expand to some degree on the actions the Committee would be expected to take. These included: • Review requests for guardianship • Review top priority individuals • Review family contacts of individuals to explore family resources as a potential guardian • For those who do not have family contacts, determine if a referral should be made to the Probate Court to obtain a guardian Facility Efforts to Obtain LARs: The Facility reported one LAR had been obtained for individuals living at DSSLC during past six months. Several other referrals and applications were in process. Other organized efforts toward appropriately obtaining LARs as well as other appropriate decision-making supports for individuals included: • Guardianship Committee: The Facility had established a Guardianship Committee, as required by the DADS and local policies, that began meeting in September 2011, as reported in the previous monitoring report. Membership appeared to be consistent with both statewide and local policy requirements, and a community member had been added in December 2102 to provide a broader perspective. Additional training was provided to the Committee on an ongoing basis at most meetings. In one such meeting, for example, a local guardianship organization provided a presentation to the Committee members as to the basics of guardianship and advocacy. The Monitoring Team was able to attend the Committee meeting held during this compliance visit. There was good attendance and participation. The meeting appeared to be largely informational as the HROs reported on their activities for individuals on the Preliminary Priority List and referrals received. Although the local policy did indicate the Committee would make certain determinations, it was unclear from the proceedings whether the Committee was expected to take action other than	

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		to receive and review the information. The Monitoring Team did recommend the Committee require that each referral and individual on the Preliminary Priority List have an expanded Rights Assessment completed such that the Committee would have the most useful information possible upon which to determine appropriate actions. • Advocacy Program: The Facility did not have an active Advocacy Program at this time. The HROs reported they were awaiting the issuance of an anticipated statewide policy. • Self-Advocacy Program: The HROs were also responsible for providing support for the Self-Advocacy Committee. The Monitoring Team reviewed the minutes of Self-Advocacy meetings held since the last monitoring visit. The review revealed that one of the meetings was dedicated to a discussion of informed consent, including specific examples about what consent might mean in relation to media coverage/photos and programmatic choices. This was a good beginning, but the Monitoring Team continues to recommend the Facility consider obtaining and implementing a formal choice-making/self-advocacy curriculum that would foster the abilities of individuals to participate in meaningful decision-making about their lives on an ongoing and formative basis. There are many good examples of such curricula for individuals with intellectual disabilities that may be adapted for use by the Facility. For example, the California Department of Developmental Services has developed a number of consumer-friendly publication and workbooks that may be useful. These can be viewed and downloaded at http://www.dds.ca.gov/ConsumerCorner/Publications.cfm. • Other Activities of the Guardianship Coordinators: Other activities included: o Between October 2011 and March 2012, the HROs attended 24 ISP meetings to provide technical assistance and consultation to teams on guardianship and rights assessment issues. o Training was provided to some teams on informed consent and decision-making needs of individuals. This included a specific instruction to the teams that guardianship is a very restrictive process and that teams should consider all possible alternatives before pursuing this course. The HROs also informed the teams they were expected to determine the specific range of individual's decision-making abilities so that guardianship would not extend beyond the areas needed. o The HROs attended guardianship training as a part of the Consumer Rights Conference in Austin in October 2012. o The HROs developed informational/training kits for family members who were to be contacted regarding their interest in becoming a guardian. o The HROs continued to complete a monthly status summary of	

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		individuals referred to the Guardianship Committee. o The HROs reported they assisted an individual living at DSSLC to complete paperwork to have a guardianship removed, at the individual's request. <u>Conclusion:</u> This Provision was found to be not yet in compliance. The Facility was to be commended for its efforts toward developing a variety of resources for individuals who require some level of assistance in making decisions, such that guardianship was not the only option. As part of undertaking an effective and appropriate large-scale effort to solicit guardians, DSSLC should ensure it has an appropriate methodology in place to determine the actual need for guardianship. DADS should provide guidance through the formal promulgation of policy as soon as possible. The Monitoring Team looks forward to seeing all aspects of support for decision-making and informed consent in full operation at the time of the next site visit.	

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

1. The Facility should consider developing specific measurable outcome indicators to be reviewed in addition to the fairly subjective process measures in the current Self-Assessment. (Self-Assessment)
2. DADS should provide guidance as to the standardized tools or methodology IDTs should use to assess and prioritize the need for an LAR, an advocate or other assistance an individual might need in decision-making. Additionally, guidance should be provided as to how, and how often, a need for guardianship should be periodically reviewed. Since the guardianship policy requires the teams to make this capacity determination, it would seem to be essential that the guidance be provided at the same time the guardianship policy is implemented. (Provision U1)
3. DSSLC should confirm with DADS that its local prioritization criteria represents an acceptable modification to the statewide policy requirements, particularly since it may impact statewide data analysis. (Provision U1)
4. The HROs should identify those individuals who had been, and seemed likely to be, without a guardian for a lengthy period and to consider how this status might factor into the prioritization. (Provision U1)
5. The Facility should consider how lack of a successor guardian should impact the prioritization criteria. (Provision U1)
6. The Facility HROs should continue to provide ongoing training to QDDPs and other PST members on the process of assessing an individual's capacity to provide consent and/or participate in decision-making regarding the individual's health or welfare. The training should be competency-based. (Provision U1)
7. DADS and the Facility should construct an evaluation plan to measure the outcomes of the Rights Assessment pilot process, both in terms of the tool and in the process teams use to complete it. (Provision U1)
8. The actual responsibilities of the Guardianship Committee under DADS Policy 019: Guardianship, effective 3/7/2012, should be clarified. (Provision U2)
9. The Guardianship Committee should require that each referral and individual on the Preliminary Priority List have an expanded Rights Assessment completed such that the Committee would have the most useful information possible upon which to determine appropriate actions. (Provision U2)
10. The Facility should consider obtaining and implementing a formal choice-making/self-advocacy curriculum that would foster the abilities of individuals to participate in meaningful decision-making about their lives. (Provision U2)

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. DSSLC Self-assessment CV4 2/2/12 2. DSSLC Action Plan 3/8/12 3. Presentation Book for Section V 4. DADS Policy 020.1 Recordkeeping Practices dated 03/05/10 5. DADS Policy 003.1 Quality Assurance 1/26/12 6. DADS Policy 019: Guardianship, effective 3/7/2012 7. DSSLC Policies and Procedures Manual Index 1/9/12 and update of 4/2/12 8. DSSLC Policy CM-25 Recordkeeping Practices 2/2/12 9. DSSLC Policy C&C-02 Quality Assurance/Quality Improvement Council 9/6/11 10. DSSLC Policy C&C-12 Administrative Review Committee 11/15/11 11. DSSLC Policy CMGMT-11 Community Activities 11/4/11 12. DSSLC Policy CMGMT 24 Procedure: Desensitization 12/15/11 13. DSSLC Policy 012.2 and CMGMT-32 (DSSLC) Physical Nutritional Management (PNM) 3/23/12 14. DSSLC Policy CMGT 27: Affirming and Protecting Rights, effective 01/20/2012 15. DSSLC Policy CMGT 30: Guardianship, dated January 16, 2012 16. DSSLC Policy CMGT 27J: Right to Autonomy, dated February 24, 2011 17. DSSLC Department Policy Pharmacy #49 Anticholinergic Policy and Procedure 12/5/11, and training sheet 18. DSSLC Department Policy Pharmacy #50 STAT Medication Policy and Procedure 12/6/11, and training sheet 19. Samples of policy draft revisions that include references to Settlement Agreement provisions 20. Settlement Agreement policy list undated, provided in email from DADS of 2/6/12 21. Training sign-in sheets and handouts for training on policies and procedures • STAT Medication Policy & Procedure • Anticholinergic Policy & Procedure • Hand Hygiene • MDRO Policy 22. Checklist for ISP packets 23. Records audit tools a. Settlement Agreement Cross-Referenced with ICF-MR Standards, Section V b. Active Record Order & Guidelines (AROG) revised 3/12/12 c. Individual Notebook and Guidelines revised 3/17/11 d. Interview Tool for use of the Record Guidelines and instructions for implementing the interview 24. Procedures for tracking findings of audits and for corrective actions—statements in document request materials

	25. Master Record Purging Schedule revised 3/30/12 26. Training description for class "Re-filing documents into the Active Record after someone is admitted to the Hospital" 27. Training description and materials for class "Contents of Individual Notebooks" 28. Individual Notebook committee meeting minutes of 2/9/12 documenting decision to change guidelines in May 2012 29. Email from Melissia Steele of 2/2/12 reminding clinicians about legibility, including signatures 30. Section V monthly graphs of compliance by monitoring tool provided to QA/QI Council for months of 9/11-1/12 31. Most recent report of data showing trends in audit findings (undated) 32. Section V Monitoring Tools Data January 2011-February 2012 33. Section V graphs of monitoring tool compliance for Provisions V1, V3, and V4 for 2011 34. Interrater reliability check between Unified Records Coordinator (URC) and Unit Clerk for Individual #310 35. Random list provided by DSSLC data analyst for audits to be done in April 2012 36. Active records and individual notebooks for Individuals #53, #149, and #679 37. Master record for Individual #53 38. Record audit completed by URC for Individual #679 39. Active record for Individual #665, and documentation of CAPs required and cleared 40. Completed audit tools and emails tracking corrective actions required for records audited for Individuals #78, #116, #172, #177, #197, #211, #229, #230, #310, #511, #526, #660, and #669 41. Active record and Individual Notebook for Individual #665 42. Settlement Agreement Provision V.4—Interview Tool for use of the Record, Guidelines, and completed form for audit of record of Individuals #211 and #310 **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, Donna Groves, Director of Habilitation, and Nancy Condon, Director of DSSKC 5. Joint interview of QDDP Coordinator Frank Padia and QDDPs Marty Mapp, Tony King, and Bryan Mitchell 6. Interviews for Use of Record—Joy Sibley, SLP, and joint interview of Randy Spence, Director of Behavioral Services, and Donna Groves, Director of Habilitation **Meeting Attended/Observations:** 1. ISP Annual Planning Meeting for Individual #53 2. Homes 506C, 514C, and 527A
	Facility Self-Assessment: The Facility Self-Assessment included a list for each provision of the activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating with rationale for the rating decision. Some of the results reported described actions that had occurred, and some provided data from reviews of

	documents, interviews, and observations. The Facility found that Provision V3 was in substantial compliance and the other provisions were not in compliance. The Monitoring Team found that no provisions were in compliance. For Provision V1, the Facility reported that monitoring tools indicated that records need improvement; although the Monitoring Team concurs based on reviews of documents and on its own audit of records, the Monitoring Team also recommends that the self-assessment provide actual data (which it already gathers and reports as part of the quality assurance process) once there is further review to ensure the data are accurate. The Facility reported data about spot checks of residential areas for security of Individual Notebooks (94%), and the observations of the Monitoring Team supported that finding. For Provision V2, the Facility provided the number of new policies and described the process of informing staff through email and "In-services…on policies as requested" and noted training is not tracked by employee. For Provision V3, the Facility stated it reviewed monitoring too data to ensure all deficiencies have been corrected, reviewed individual notebooks, active records audits, and results of monitoring tools to determine interrater reliability on records audited, and stated these audit results show 100% reliability; however, the audits provided by the Facility in response to a records request did not show 100% reliability. Instead of having a separate process for the self-assessment, the Facility should use data it collects routinely, which will provide more data and allow integration into the Facility's regular quality assurance process. For Provision V4, the Facility reported it reviewed the results of the interview tool for use of records, the results of the IPN audit, interviews with Facilitators to determine if records are reviewed at ISP meetings, and assessments on facility wide delinquency list and assessment tracking database. The Facility provided data on results of the interviews and IPN audits that documented a high level of use, and rated noncompliance because assessments are not posted in the shared folder within 10 days of the ISP. The Monitoring Team recommends an additional type of review; the Facility should develop a process to assess whether information in the record is present as required (so that it can be used) and is used both for making decisions and for implementing supports and services on an ongoing basis. The Facility also provided an action plan for reaching compliance. For each provision, this plan described actions that were in process or not yet started. Rather than an overall plan for ensuring records are accurate, timely, accessible, and used for making decisions, the action plan is a set of different activities to accomplish specific tasks. Although the tasks themselves may be important, they do not establish a sequential order of actions that build on each other to reach a defined recordkeeping system. In part, this is understandable, as Provision V2 is actually a separate issue from recordkeeping; as far as recordkeeping is concerned, though, the Facility should develop a vision of what the system should be like and how it should work, should identify the gaps between the current system and that vision, and should identify sequential as well as concurrent steps to develop the desired system.

	Given the specific steps in the action plan, most of them seem appropriate and necessary but not sufficient to accomplish compliance. For example, in Provision V1, the Facility plans to clarify guidelines for filing in the IPN, develop a process for accurate filing and purging forms in the Individual Notebooks, provide training to staff on documentation, and develop a system to ensure the Individual Notebooks are secure. All these should be done (and, in fact, based on the observations of the Monitoring Team and on self-assessment data, security of the Individual Notebooks has been achieved and now needs only to be maintained), but they will not by themselves accomplish the goal of accurate and timely documentation. In the same way, the action step for Provision V4 is to develop a database for tracking the interview tool; that will not accomplish the goal of ensuring information is present and is used in implementing programs and making decisions.
	Summary of Monitor's Assessment: The Facility continued to make progress on all provisions of this section. The Facility maintained a unified record as well as a shared drive that can make useful information (such as assessments) accessible to the IDT. Nevertheless, the Facility had not yet come into substantial compliance with any provision. For Provision V1, the Facility had policy to guide recordkeeping and that included all requirements of the DADS Recordkeeping policy. 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. Records were accessible to staff (and security of records had improved without limiting access), and staff could identify where in the records to find documents. Most, but not all, documents that were required to be in the Active Record were present. Legibility had improved. Nevertheless, there were a large enough number of documents not present and of other types of errors so that the Facility had not yet reached substantial compliance. Given the continuing improvement and the potential for systemic improvements resulting from audit information, the Facility should be able to resolve continuing issues, minimize errors, and establish a compliant unified record. For Provision V2, there has been continuing development and implementation of policies to address the requirements of the Settlement Agreement. There are still policies that need to be developed or revised at both the DADS and Facility levels. Furthermore, continuing efforts must be made to ensure policies are implemented accurately. One means to achieve more accurate implementation would be development of a more structured way to identify what policies require training, what that training should consist of, and how knowledge of the policy and competence at implementing requirements of the policy should be assessed; then, tracking of completion of training for each staff member should be established and monitored. For Provision V3, there is a robust audit system in place. Improvements made since the last compliance visit include random selection of records to be audited and independence of interrater reliability checks. Although reliability between records clerks and the URC was high on the monitoring tool, the Monitoring Team did not find the same level of agreement; further definition of items being checked should be done, and there should be clarification of how the forms are to be marked (or revision of the forms to make them clearer). Follow-up on items needing correction (whether corrections to the documents or corrective

	actions to minimize errors, such as retraining) have been completed consistently, and the Facility has an excellent process to ensure reported corrections were actually implemented. Although some systemic actions have been taken to address documentation issues, there has not been review of the effectiveness of these actions except for review of the monitoring tools. For Provision V4, clinical staff report use of information in the record for making decisions. The Facility reviewed IPNs to determine whether documentation provided evidence that several disciplines made entries. Availability of the record and use of information from the record at IDT meetings was evident. However, the Facility did not have a process to determine whether information in the record was used effectively to identify progress or decline in health and behavioral status of individuals for purposes of making treatment decisions, and the Monitoring Team found information missing but not commented on in reviews. Also, the Facility did not have a process to determine, evaluate, and identify trends in use of the record to guide implementation of programs, and the Monitoring Team found evidence of lack of use of the record based on lack of implementation of programs.

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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 (ME Book). 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 ISP, 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 IDT. Recordkeeping was to follow DSSLC Policy CMGMT-25 Recordkeeping Practices. This policy operationalized to the Facility the DADS Recordkeeping Practices policy. 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. At the last compliance visit, the Monitoring Team reported that recordkeeping was	Noncompliance

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		improved. Further improvement had occurred. 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 and Individual Notebook for Individuals #53, #149, and #679, and the Master Record for Individual #53. 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 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 #53, 89% of documents were present. • For Individual #149, 90% of documents were present. • For Individual #679, 82% of documents were present. These percentages were relatively consistent with the findings at the last compliance visit, although Individual #679—who had been admitted since the last compliance visit--showed a lower percentage. 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 Homes 506C and 514C and found the records (both the Active Record and the Individual Notebook)	

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		for Individuals #53 and #149 were accessible but also were kept where they were not open to view by people who did not have a need to see them; when asked, staff were immediately able to provide the Individual Notebooks for both these individuals. In addition, the Monitoring Team observed several other living units and found that records were kept where they were not readily visible but remained accessible to staff. This was an improvement since the last visit, when Individual Notebooks were not secure. Furthermore, at the last visit, some information was not readily accessible, such as the PNMPs for some individuals; individuals living at Houston Park or Cedar Falls did not have their individual notebooks follow them and therefore the PNMPs were not readily available to staff. At this visit, however, that was corrected, as the individual notebooks did follow the individuals. Other monitoring activities found both improvements and issues remaining. • As reported in Provision F2c, Staff were consistently able to locate the record and the programs found in the ISP. Although the Monitoring Team found staff were not consistently able to describe the contents of the ISP or programs without referring to the documents (see below), they were able to locate the information with relative ease when asked. For example, as reported in Section O, when asked, ten of ten (100%) staff knew where the PNMP was located. • As reported in Provision M1, legibility of the nurses' handwriting had progressively improved since the last review. Also, Records were made available onsite without difficulty or delay. o Errors made in documentation were not corrected properly with a straight line drawn through the entry, dated, and initialed. o It was discovered when looking for individuals' active Acute Care Plans, that they were kept the Red Care Plan Book in the Units/Homes for ready access. When active problems were resolved the Acute Care Plans were filed in the unified record. The Red Care Plan Books were not part of the unified records. If the nursing staff had not assisted with securing the Acute Care Plans from the Red Care Plan Book, it would have been assumed there was no Acute Care Plans for the individuals the Monitoring Team was attempting to review. The Monitoring Team assumes staff at the Facility are aware of the Red Care Plan Book, but separate books for active documents such as this should be noted in policy about the Unified Record. Furthermore, because there is potential for documents not to be moved to the Active Record, the records audit process should include some means to audit such other books or otherwise ensure documents are moved as required and are current in all books. o Numerous emails were provided to demonstrate integrated communication with other disciplines. The emails contained pertinent	

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		clinical information that should have been included in the Integrated Progress Notes. While emails were a quick and easy way to communicate with other disciplines, the failure to include relevant clinical information in the Integrated Progress Notes had the potential to interfere with continuity of care. • As reported in Provision L1, the most recent two IPNs for each practicing clinician were reviewed to ensure that they were timed and dated. Of the 20 IPNs reviewed, 20 (100%) were timed and dated. • As reported in Provision F2d, quarterly reviews were not always found in the active record. Although the Monitoring Team understands that there is no way to prevent occasional errors in such a large number of records, there was indication that the audit process and other activities had not yet led to minimization of errors adequate for a finding of Substantial Compliance. The Monitoring Team expects that the audit process will lead to systemic corrective actions that will result in improved accuracy. Review of the Master Record for Individual #53 found it to be accessible, and it appeared to have the required information present and filed appropriately. The Facility did not have a process other than audits to 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 IDT. The Personal Support Plan Policy III.D requires IDT members to file their assessments and recommendations on the Share drive 10 days prior to the PSP meeting, and requires IDT members to review all assessments "to prepare for a comprehensive, integrated discussion during the PSP meeting." QDDPs provided the Monitoring Team, through interview, 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. Furthermore, QDDPs reported the records clerks track the share drive to see if assessments are present as required. As reported in Sections F, K, and S, many assessments were not completed and posted to the active record by the required timeline of 10 days prior to each individual's ISP annual planning meeting. The Share Drive also had other uses. To improve accessibility of information for use by	

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		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 continuing improvement and the potential for systemic improvements resulting from audit information, the Facility should be able to resolve continuing issues, minimize errors, and establish a compliant unified record.	
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 discussed throughout this report, policies and procedures necessary to implement the Settlement Agreement (SA) 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. <u>Statewide Policies</u> DADS provided a list of policies referenced to the SA. According to this list, Policy 003 Quality Enhancement had been revised and made effective since the last compliance visit. DSSLC needs to revise its Facility-specific quality assurance policies to reflect any DADS requirements that are not already in Facility policy. As reported in Provision U1, DADS State Office had issued a new Policy 019: Guardianship, effective 3/7/2012, with five Exhibits; please refer to Provision U1 for discussion of this policy. The Monitoring Team remained concerned that the new policy, while requiring IDTs to make an assessment of an individual's decisional capacities, provided little to no guidance as to how this assessment should be accomplished. DSSLC had localized DADS Policy 019 in DSSLC Policy CMGT 30: Guardianship, dated January 16, 2012. The local policy had a number of modifications from the new statewide policy, and most seemed to be internally consistent with the DADS document; however, the Facility may want to review the local policy to ensure it comports fully with the newly issued Policy 019. The Facility had also promulgated DSSLC Policy CMGT 27: Affirming and Protecting Rights, effective 01/20/2012. Exhibit A to the policy was a Rights Assessment document, Form 6614, dated September 2011, which included an expanded section for assessing an individual's ability to provide informed consent. There were several other policies still in draft form that address such sections of the SA as Integrated Protections, Services, and Supports; Psychiatric Care and Services; Medical Peer Review; and Skill Acquisition. Continuing development of such policies will be needed to ensure the Facilities have the guidance needed to comply with this provision. <u>Local Policies</u> Lori Powell, Director of Quality Assurance (QA), described the Facility's process to develop or revise policies. This process had not changed since the last compliance visit.	Noncompliance

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		As statewide policies are implemented, the Facility will establish localized policies to operationalize them. The Facility provided samples of draft policy revisions using a revised format that contains references to specific Settlement Agreement (SA) provisions. The Facility reported plans to develop a spreadsheet that will list policies and the provisions they cover. This should help the Facility ensure that policies are in place to govern all requirements of the SA. Per information provided through the document request, the following policies relevant to the Settlement Agreement were implemented or revised since the last compliance visit: • DSSLC Policy CM-25 Recordkeeping Practices 2/2/12 • DSSLC Policy C&C-02 Quality Assurance/Quality Improvement Council 9/6/11 • DSSLC Policy C&C-12 Administrative Review Committee 11/15/11 • DSSLC Policy CMGMT-11 Community Activities 11/4/11 • DSSLC Policy CMGMT 24 Procedure: Desensitization 12/15/11 • DSSLC Policy CMGT 27: Affirming and Protecting Rights, effective 01/20/2012 • DSSLC Policy CMGT 30: Guardianship, dated January 16, 2012 • DSSLC Policy CMGT 27J: Right to Autonomy, dated February 24, 2011 In addition, the Director of Quality Assurance reported the following policies had been revised, including policies revised since the document request list (the Policy Manual Index) was prepared: • DSSLC Policy 012.2 and CMGMT-32 (DSSLC) Physical Nutritional Management (PNM) 3/23/12 • At Risk policy • Comm/Councils 14 Ethics Committee 3/1/12 • CMGMT 03 Integration of Clinical Services 3/27/12 The Monitoring Team also identified new or revised departmental policies that address requirements of the SA, including: • DSSLC Department Policy Pharmacy #49 Anticholinergic Policy and Procedure 12/5/11 • DSSLC Department Policy Pharmacy #50 STAT Medication Policy and Procedure 12/6/11 The Monitoring Team asked the Director of Quality Assurance whether there had been changes in the process to notify staff of new and revised policies and was informed that there had not been changes.	

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		When a policy is implemented or revised, a notice is to be sent to relevant staff. Examples of these were provided; one was an email about "Updated Policy Statement- "Community Activities" sent by Nancy Condon, Facility Director. This email stated the purposes of the policy and checked a checklist item that stated the policy applies to "all DSSLC employees, persons served, volunteers & visitors." The person responsible for developing the policy identifies the training needed and sends the list to Quality Assurance. The person responsible for training returns training sheets to Quality Assurance. There is not typically a test for knowledge or competency. The Facility provided numerous training sheets for many of the policies that had been revised or implemented. In addition, the Director of Quality Assurance described a campus-wide skills fair in February and March 2012 at which over 500 DCPs were trained on policy for PNM/mealtime standards/position and communication; this training was competency-based. The Facility also provided attendance sign-in sheets for numerous policy and procedure trainings, including the following: • STAT Medication Policy & Procedure • Anticholinergic Policy & Procedure • Hand Hygiene • MDRO Policy For some of the trainings, handouts and/or an outline of training was provided. It was clear that training, in most cases, was planned and organized. It was not clear whether there was any competency assessment of either knowledge or performance for most. The Monitoring Team does not suggest that every change in policy requires competency testing; the Facility must determine, for each policy or procedure implemented or revised, what documentation is needed to ensure staff are aware of the policy and when competency testing is important; this determination should be documented so expectations are clear. This report notes examples of knowledge and accurate implementation of policies. For example: • As reported in Provision C1, staff understood that prone restraint is prohibited and what restraints are permitted. • As reported in Provision M1, the Facility had obtained and had in place all of the required emergency equipment, including the AEDs as required by revised Emergency Response Policy. • As reported in Provision O5, the PNM Policy also stated that PNMPs will be trained upon development as determined by plan revisions. Per review of training required for PNMP revisions (Sample#2); trainings occurred in	

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		response to revisions five of five (100%) opportunities. As noted throughout this report, there were many examples in which policies were not fully implemented. For example: • As reported in Provision C1, the policy and procedure related to Medical/Dental Sedation and Restraint was not being implemented consistently with a high degree of accuracy. • Although Facility policy requires that staff report (and report timely) allegations of abuse, neglect, and other serious incidents, consistent implementation of timely reporting needs to be addressed. The frequency of untimely reporting is unacceptable • As reported in Provision I3, the At Risk Individuals Policy and instructions required the relevant disciplines to complete their risk assessments 10 days prior to the ISP date and make them available to the RN Case Managers to review in collaboration with the responsible physicians, but risk assessment information was not consistently available in that timeline. • As reported in Provision M1, risk ratings did not always reflect clinical data to justify the ratings, as required by the At Risk Individuals policy. • As reported in Provision T1c1, there were concerns related to adherence to policy, such as the identification of Facility staff to ensure each prescribed support was implemented as required. For compliance, both DADS and the Facility must: • Complete development, revision, and implementation of policies needed to implement all provisions of the Settlement Agreement. • Develop a more structured way to identify what policies require training, what that training should consist of, and how knowledge of the policy and competence at implementing requirements of the policy should be assessed; then, track completion of training for each staff. • Ensure policies are fully and accurately implemented.	
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	The Facility had a process in place to audit five randomly selected records each month. The Facility's data management department provided a list selected by computer of five individuals across the whole Facility. The process calls for the records clerk for a sister unit to audit the record and enter the ratings into a database. The URC also was to audit all five records. Copies of audits done for the months of December 2011 through March 2012 verified that both the records clerks and the URC did five audits per month (of which four were interobserver reliability audits). 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	Noncompliance

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	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.	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 these audits independently and did not share findings until both were completed. Because four of 12 records clerks received an interobserver reliability audit each month, and these were rotated across clerks, each clerk received such an audit every quarter (with an occasional revision to this schedule if random selection of individuals did not produce a sister unit audit for a clerk due for an interobserver reliability check in a specific month). This appears to be an acceptable means for scheduling and implementing interobserver reliability checks, with the caveat that it would be better for both raters to rate on the same day (and, preferably, before any additions or changes can be made to the record). <u>Interrater Reliability between URCs and Records Clerks</u> The Facility had calculated and provided to the Monitoring Team interrater reliability between the URC and the records clerk. Agreement on the Settlement Agreement Cross Reference with ICF-MR Standards form as calculated by the Facility ranged from71% to 100% with a mean of 86% and a median of 82%. The Monitoring Team reviewed the forms for Individual #197 (whose reported agreement was 85%, just below the average) and found two items that should have been marked as disagreements but were not (one was marked NA by the records clerk and Yes by the URC, and the other was blank on the records clerk's form and Yes on the URC's form); it is possible one of these was not considered in the calculation, as the total number of items (out of 29 on the form) was listed as 28. Therefore, a second form was checked, for Individual #310 (whose reported agreement was 93%); this used an updated form. For this form, the Monitoring Team found one item for which the rating on the record clerk's form stated NA and on the URC's form stated Y, but this was not marked as a disagreement. It appears there needs to be clarification on how to mark agreement when one rater marks NA. Agreement on the Active Record Order & Guidelines and Individual Notebook presence of items ranged from 87% to 97% with a mean of 93% and a median of 93%. The Monitoring Team reviewed these forms for Individual #197 but could not determine precisely what the agreement was, because it was unclear which items were not present but not considered required by one auditor (possibly, those were items that had a blank cell) versus not present but required (possibly, those were items with a vertical line). It is possible the Facility had a standard practice for that, but the Monitoring Team could not be sure. Even so, the Facility had a process in place that could, with minor adjustment, provide adequate and accurate information on interrater reliability. <u>Agreement in Ratings Between URC Audit and Monitoring Team Audit</u> The Monitoring Team conducted an independent audit of the record of Individual #149, who was selected by computer randomization from the five audits to be done in April	

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		2012. The Monitoring Team was provided with the active record immediately following the audit by the URC and went to the home to review the Individual Notebook on the same day. During the compliance visit, the Facility notified the Monitoring Team that revisions had been made to the audit form to improve clarity of certain items, based on discussion with the Monitoring Team. The interrater reliability check conducted by the Monitoring Team used the current audit form without these revisions. Unfortunately, on the Settlement Agreement Cross Referenced with ICF-MR Standards, the Monitoring Team and URC had only 48% agreement on 27 items (the Monitoring Team did not score two items (the Interview Tool for V4, which would not yet have been completed, and whether information was adequate for decision making). Ten items marked "Y" by the URC were marked "N" by the Monitoring Team, one marked "Y" by the URC was marked "NA" by the Monitoring Team, and three marked "N" by the URC were marked "Y" by the Monitoring Team. This does not mean one or the other rated more accurately; instead, it indicates likelihood that better definition for the rating items is needed. Given the much higher agreement between the URC and records clerks, it is likely they have developed understandings of the requirements for items that have not been written in the definitions. The definitions need to continue to be improved; to determine whether the definitions are adequate, it would be good to have an independent auditor who has not been part of the discussions about ratings do a rating periodically. However, on the AROG, the Monitoring Team and URC achieved 91% agreement on presence of items. One item with consistent disagreement was titled "Code Status & Advance Directives"; the URC always found this, and the Monitoring Team did not. This may have been an issue of title of a document. There was a document titled "Client Data Form Code Sheet" that was not listed on the AROG, and that was consistently present, but it did not list whether there was an advance directive or No Code status. It is important that the Facility ensure titles on the AROG are as consistent as possible with the actual titles of documents in the record. For the Individual Notebook, the Monitoring Team and URC achieved 80% agreement. However, this might have been a low figure. The individual had recently had an ISP annual planning meeting, and some programs had been revised; the updated training programs were in the Individual Notebook (which verified they had been initiated) but the ISP had not yet been put into the Individual Notebook (and was still within the policy-approved timeline for such entry), so some disagreements between those documents may have led to reduced interrater reliability. Therefore, the Monitoring Team believes ratings of presence of documents in both the AROG and Monitoring Team are (with the exception identified above) adequate, and compliance percentages for these identified in the monthly audits were accurate.	

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		Until the ratings are clearly accurate, the data used for decision-making must be viewed with an understanding that they may not be accurate. <u>Corrective Actions</u> 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 from December 2011 through February 2012 notifying staff of required corrective actions based on audit findings. All had documentation of notice of deficiencies and corrections needed. Reviews of audits compared to emails notifying staff of needed corrections indicated that virtually all items noted as not compliant or accurate were addressed. 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 Monitoring Team randomly selected one record from the March audits. The URC had sent an email notifying staff that all CAPs had been cleared and provided the Monitoring Team with copies of inservice sign-in sheets from February documenting retraining of nurses had already been done that covered errors that were found in this audit; the audit did not identify whether these errors occurred after the training or only before. This retraining had been provided as a result of findings of earlier audits, indicating that the Facility was identifying common errors and addressing them. The Monitoring Team, accompanied by the URC, reviewed the Active Record at the home, with no prior notice that this would be done. All errors that were correctable and were identified as cleared had been corrected. <u>Review of Trends and Resulting Systemic Actions</u> The Facility reviewed findings of the audits at the QA/QI Council meetings. Trend data were reported from the Settlement Agreement Cross Referenced with ICF-MR Standards tool and were presented in bar graphs for quarterly averages for selected items and line	

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		graphs for overall compliance and by provision each month. As noted above, the data from the audits still may not be accurate, so care must be taken in making decisions on actions to correct and improve records. One change that had been made based on identified trends was greater detail about legibility and gaps put into Policy CM-25 Recordkeeping practices in February 2012. Those issues were included in an item that had not met 80% compliance in the period from January 2011 through February 2012. Not enough time had passed since that change in policy to determine whether it had any effect. Prior to the last compliance visit, there had been a memo to medical staff (5/10/11) instructing them about gaps in records; initial follow-up found no improvement. Although the Facility checks this issue in audits, there had been no specific system-wide review to determine whether this had resulted over time in a positive effect, and the only follow-up reported was another memo. The Facility plans to check this in part by reviewing a relevant question in the external medical audits. <u>Conclusion</u> Although five randomly-selected records were reviewed monthly, and the Facility had a structured process to do these audits that included checks for interobserver reliability, and a structured process to track and ensure completion of corrective actions for audited individual records, compliance will also require improved definition of items to ensure accuracy of data, and tracking of effectiveness of system-wide corrective and improvement actions.	
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 continued processes to monitor and evaluate how records are being used. One such process is the deficiency list implemented prior to the last compliance visit of assessments due on the Share Drive but not posted. Unless assessments are posted, they cannot be reviewed easily by all IDT 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. As noted in Sections F and K, assessments were not yet consistently posted as required by policy. Another process is an interview of IDTs using a standard format. The URC selected one individual per month from the audited records. For that individual, she asked two staff from the individual's IDT 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 IDT member used information from the record in making a decision about the individual and	Noncompliance

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		an example of how a report from another discipline helped the IDT member plan a treatment or intervention, and how the record is used in meetings. For each IDT 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 IDT used the information in the record and recorded that on the Settlement Agreement Cross Referenced with ICF-MR Standards Form. Other than inclusion as one item on that form, there was no process in place to assess interobserver agreement on the ratings or to track and trend any of this information separately. Reviews of interviews provided by the Facility documented that staff were able in all cases to give an example of a way in which they used the records in making decisions. Two of three were very general in providing an example of a report from another discipline that helped in planning a treatment or intervention, giving general types of documents and decisions rather than a specific example; the URC should probe further to ensure the staff can provide actual examples. All reported the records are available at meetings; one reported it is not regularly used, because the needed information has already been gathered, but it is available if questions arise. The Monitoring Team interviewed three staff (one individually, and two in a group interview) using a tool that included the same questions and some additional questions. All three staff provided examples of information from the record used in making decisions as well as specific examples of information they use from other disciplines. They all identified information from the record that is used at meetings. A third process was the inclusion on that form of a question about whether information from review of the record (IPNs) provided evidence that the Facility routinely uses the records to make decisions; per the guidelines, this required that more than five disciplines wrote in the IPNs during the prior six months. Data from the records audits by the Facility showed this to occur in most cases. However, on the interrater reliability between the URC and the Monitoring Team, the Monitoring Team found this did not occur (there were five disciplines with entries in the IPN) and the URC found it did occur. It will be essential to ensure accurate audits. To verify whether the record was available and used at IDT meetings, the Monitoring Team observed for this at the ISP annual planning meeting for Individual #53. The Active Record was available. However, it was not referred to, as the IDT members each had information needed from the record readily available. As appropriate, data were reported rather than general impressions. Although the record itself was not referred to, it was clear that information had been excerpted from the record in advance and reported at the meeting for interdisciplinary discussion.	

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		The Facility did not have a process to determine whether information in the record was used effectively to identify progress or decline in health and behavioral status of individuals for purposes of making treatment decisions. There were examples in which data were missing without comment in reviews or were not used to make decisions. For example: • As reported in Provision K4, data were missing but not discussed in progress notes. For Individual #605, staff submitted only 72% of the expected data collection forms from the previous month. For this same individual, data tables included in the progress note included several instances of missing data relating to psychiatric symptoms and behavior correlates. The missing data were not discussed in the progress note. • As reported in Provision K4, only three of the eight records reviewed (38%), there were indications that treatment decisions were based upon available data and reflected either appropriate revisions following increases in treatment targets or an adequate response to treatment that negated the need for any revision. Individual #50 experienced an increase in insomnia in July 2011 that continued for several months. Verbally disruptive behavior, as well as aggression against people and property, increased in October of 2011 and remained elevated for several months. Neither progress notes nor treatment documentation reflected any attempt to revise the PBSP or psychotropic medication regimen during the noted increases in behaviors and symptoms. The Facility did not have a process to determine, evaluate, and identify trends in use of the record to guide implementation of programs. Although staff were able to state where in the Individual Notebook to find documents such as ISPs, PBSPs, and PNMPs, the Monitoring Team noted that these plans were often not followed and did not see examples in which staff referred to them. For example: • As reported in Provision O4, although the PNMPs were provided at various locations, at no time during any of the observations was staff observed referring to the PNMPs. • As reported in Section R, staff were not knowledgeable of communication programs, and although AAC devices were available, they were not consistently used. • As reported in Provision S3(a), SAPs were not implemented accurately.	

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

1. The Facility should develop a process to determine whether all documents that should have been purged have actually been purged and sent to Central Records. (Provision V1)

2. Develop a more structured way to identify what policies require training, what that training should consist of, and how knowledge of the policy and competence at implementing requirements of the policy should be assessed; then, track completion of training for each staff. (Policy V2)
3. Definitions of audit items for the Settlement Agreement Cross Referenced with ICFMR Standards tool need to continue to be made clearer. Until the ratings are clearly accurate, the data used for decision-making must be viewed with an understanding that they may not be accurate. (Provision V3)
4. The Facility should monitor the effectiveness of systemic corrective and improvement actions. (Provision V3)
5. Develop processes to determine whether information in the record was used effectively to identify progress or decline in health and behavioral status of individuals for purposes of making treatment decisions, to comment on missing information needed for decision-making, and to monitor use of the record to guide implementation of programs. (Provision V4)

List of Acronyms

Denton State Supported Living Center
April 2-6, 2012 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
APL	Active Problem List
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
AROG	Active Record Order & Guidelines
AS	Action Step(s)
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BIR	Behavioral Incident Report
BMC	Behavior Management Committee
BP	Blood Pressure
BSP	Behavior Support Plan
BSRC	Behavior Support Review Committee
CAP	Corrective Action Plan
CBC	Criminal Background Check or Complete Blood Count
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
DSP	Dental Support Plan
DUE	Drug Utilization Evaluation
EC	Environmental Control
EEG	Electroencephalogram
EKG	Electrocardiogram
ER	Emergency Room
FA	Functional Analysis or Functional Assessment
FAST	Functional Assessment Screening Tool
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
HIM	Health Information Management Department at Rio Grande State Center
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
ICM	Integrated Clinical Meeting
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
IRR	Integrated Risk Rating
ISP	Individual Support Plan
IT	Information Technology
i.v./IV	Intravenous
LA	Local Authority (formerly MRA)
LAR	Legally Authorized Representative
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MAS	Motivational Assessment Scale
MBSS	Modified Barium Swallow Study
MD/M.D.	Medical Doctor
MOSES	Monitoring of Side Effects Scale
MP	Medication Plan
MR	Mental Retardation
MRA/MHMRA	Mental Retardation Authority/Mental Health and Mental Retardation Authority
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus Aureus
MSP	Medical Support Plan
NA	Not Applicable
NANDA	North American Nursing Diagnosis Association
NCP	Nursing Care Plan
NDC	Non Direct Care/No Direct Contact
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
PBMC	Psychiatric and Behavior Management Clinic
PBSC	Positive Behavior Support Committee
PBSP	Positive Behavior Support Plan
PBST	Personal Behavior Support Team
PCD	Planned Completion Date
PCP	Primary Care Physician
PDB	Physically Disruptive Behavior
PDP	Personal Development Plan
PFA	Personal Focus Assessment
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
PTP	Psychiatric Treatment Plan

PTR	Psychiatric Treatment Review
QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QI	Quality Improvement
QMR	Quarterly Medication Review
QMRP/QDDP	Qualified Mental Retardation Professional/Qualified Developmental Disabilities Professional
QPR	Quarterly Psychiatric Review
RC	Restraint Checklist
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
SFA/SFBA	Structural and Functional Assessment/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
TO	Training Objective
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
WBC/wbc	White blood cell

x/o	Rule out