# United States v. State of Texas

## Monitoring Team Report

## Denton State Supported Living Center
## October 8-12, 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 Director, Nancy Condon, was extremely supportive of the Monitoring Team's activities throughout the week of the compliance visit. 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, Serena Knox, and the staff who assisted her to keep up with all our requests, especially Cheryl Lutzen, Katie Eberle, Wes Knox, Billy Hensley, Lori Powell, and all the Records Clerks. 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.

**General Comments**

Population. Population of the Facility at the beginning of the compliance visit was 492 individuals.

Facility Self-Assessment. The Facility provided a self-assessment for each section of the Settlement Agreement. For the self-assessment, the Facility reported for each provision the activities engaged in to conduct the self-assessment, results of the self-assessment, and a self-rating with rationale for the rating. The self-assessment process has become more thorough and objective. In general, improvement was noted in the organization and presentation of the Self-Assessment. A notable attempt had been made to mirror the tools and processes used by the Monitor. However, as indicated in each of the sections of the report below, self-assessments varied greatly across sections of the Settlement Agreement. There was greater use of data in most Sections. For some sections, the Facility used data gathered as part of routine quality assurance and quality improvement activities, which is commendable. In other cases, data were gathered specifically for the self-assessment. In many cases, data were not gathered at all. In some cases, data that represented positive findings was, and in other cases was not, verified by the observations done by the Monitoring Team. For many provisions, the self-assessment did not cover all essential requirements of the provision. The Monitoring Team provides, in this report, specific reviews of the self-assessments, including recommendations 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, the Facility provided for each Section of the Settlement Agreement provisions an Action Plan listing actions to be taken to move forward toward compliance. These plans were quite variable across Sections. Some provided stepwise and sequential plans, at least in part. Others were lists of activities, many completed and many described as in process. 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

The Facility had made continued progress in achieving compliance in Section C. One additional Provision was in compliance and several more are close to compliance. As noted in the last several reports the major barrier to additional compliance was various aspects of the administration and monitoring of medical restraints.

- Positive Practices and Improvements Made
    - The Facility had revised its restraint policy CMGMT-20 to reflect the requirements of the new State policy. Implementation was well underway.
    - The use of crisis intervention restraint at the Facility had steadily decreased over the last several reviews and remained low. Since the last review, crisis intervention restraint was used only 17 times with eight different individuals.
    - All required staff training (for staff in general, and specifically for staff acting as Restraint Monitors) had been completed.
    - Facility policy prohibits prone restraint and this prohibition is reinforced through staff training. The Monitoring Team review of restraint records, restraint reduction committee minutes, and minutes of the Incident Management Review Team (IMRT), did not discover any use of prone restraint.

- Improvements Needed
    - The Facility's Restraint Trend Report (8/31/12) did not report any longitudinal data on the use of medical restraint. While the Restraint Trend Report did not include longitudinal data on the use of medical restraint, a review of the log presented by the Facility in response the Monitoring Team's document request suggests the use of medical restraint had increased significantly, while the development of treatments and strategies to minimize the use of medical restraint has lagged.
    - The Primary Care Physician (PCP) did not document that the intensity and frequency of the self-injurious behavior presented imminent risk of serious physical injury. Furthermore, monthly IDT reviews did not include a reevaluation by the PCP that the intensity and frequency of the self-injurious behavior warranted continuation of the restraint plan.
    - As in past reviews, inconsistent restraint monitoring by nursing staff was noted and needs to be aggressively addressed.

<u>Abuse, Neglect and Incident Management</u>

The Facility was found to be in substantial compliance with a number of provisions and components of provisions in this section of the Settlement Agreement and does many things well. This is an increase in compliance compared to what was noted in the last report.

- Positive Practices and Improvements Made
    - The Facility process for review of DFPS investigation reports had substantially improved compared to what was observed at the last review.

- The Facility improved its practices in reviewing DFPS reports and following up with DFPS on issues, including when necessary conducting follow-up investigations after assessing the completeness and accuracy of a DFPS report. The Facility is to be commended for its improvement in reviewing DFPS investigations.
- The Facility was doing a good job of completing follow-up investigations when they receive an administrative referral back from DFPS.
- The Facility demonstrated 100% compliance with the staff training requirements associated with abuse, neglect, and exploitation, and unusual incidents. Staff knowledge, when queried by the Monitoring Team, was variable.
- 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.
- In all but one allegation of physical abuse in the sample drawn by the Monitoring Team, law enforcement notification occurred.
- Compliance with required background checks was confirmed.

- Improvements Needed
  - Late reporting of serious incidents was still a problem.
  - The thoroughness and completeness of DFPS investigations was still a problem.
  - The Facility determines a cause for every discovered injury often based on little or no evidence. Typically a plausible probable cause is determined based on various opinions expressed by staff, usually related to the individual's general demeanor and behavior, but not supported with any specific evidence related to the specific injury.
  - Facility investigation reports of serious discovered injuries were not always sufficient in scope and depth to provide a clear basis for investigation conclusions.
  - 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.) and other variables, including data that can tell the Facility, for example, if the frequency of confirmed and/or inconclusive findings is increasing or decreasing and at what locations and work shift. Trend data should be presented in a manner that lends itself to useful analysis, discussion, and decision-making.

<u>Quality Assurance</u>
The work effort observed during this monitoring visit demonstrated continued improvement in the development and implementation of some components of an effective QA system although much remains to be done.

- Positive Practices and Improvements Made

- 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 Facility revised trend data to include longitudinal data.
- The Facility had identified a set of key indicators it believes it should use to track organizational performance. Data affecting the key indicators is regularly reviewed in the QA/QI Council.

- Improvements Needed.
  - The Facility was unable to describe any process to determine if a Corrective Action Plan (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.

<u>Integrated Protections, Services, Treatments and Supports</u>

There are areas of significant progress in this Section, as well as areas of little progress. A new ISP planning process was put in place and needs time to be fully implemented. Much of the focus of the compliance review was on the new process and the two ISPs that were planned and prepared using this process and format.

- Positive Practices and Improvements Made
  - The Facility continued to devote considerable resources to training, monitoring, and coaching for QDDPs, an effort the Monitoring Team commends. The Facility had added a Facilitator Coordinator position, whose job description indicated he was responsible for ensuring all QDDPs become competent in facilitating meetings. In addition, the Facility had offered a QDDP Skills Fair, brought in an external resource to provide training on development of Skill Acquisition Plans (SAPs), and offered competency-based training on completing the Rights Assessment.
  - The Facility had initiated a focus on enhancing the timeliness and quality of assessments. Although timeliness remained an issue, preliminary indications were that the new focus may have led to improvement.

- Improvements Needed
  - The ISP process was still meeting with limited success specific to the requirements of this Section. 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 had made some improvements in ensuring an assessment of progress on a monthly basis, or more frequently as needed, or making revisions if there was a lack of expected progress. Overall, however, 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.

- The Facility did not consistently ensure that programs or services prescribed in the ISP were modified as needed. Monthly/Quarterly reviews also indicated that individuals' ISPs were not consistently put into effect within 30 days of preparations.

Integrated Clinical Services

The Facility had continued to progress toward providing clinical services in an integrated manner Policies and processes to improve integrated planning both for individuals and for systemic improvements continued to evolve. Nevertheless, integrating planning and services across disciplines remained a challenge, and this provision was not yet in compliance. The Facility had made significant progress in documentation and follow up to recommendations from consultations by non-Facility clinicians.

- Positive Practices and Improvements Made
  - Facility physicians documented review of recommendations from non-Facility clinicians.

- Improvements Needed
  - Improvement still is needed in integrating planning for supports and services for individuals and particularly in ensuring they are integrated into and become part of the ISP. The Facility must identify areas in which improvement in both the activities and documentation of integrated planning, and in the evidence that treatments and interventions involve integrated planning, are integrated into ISPs.
  - There was no evidence of referral of consultant recommendations and Facility clinician plans to IDTs on the consultation forms or integrated progress notes.

Minimum Common Elements of Clinical Care

The Facility had continued to work diligently on improvements in timeliness and comprehensiveness of assessments, development and use of clinical indicators, and maintenance of systems to address chronic conditions, and is approaching compliance with several provisions. As these develop, the Facility will need to ensure policies provide guidance, and the systems are organized so it is clear how all come together to meet the needs of individuals for supports and services and also affect system wide improvement.

- Positive Practices and Improvements Made
  - An example of such an organized process is the diabetic management system. The Diabetic Management Review of 9/14/12 not only provided data on incidence of hypoglycemia and hyperglycemia but also provided an evaluation of the status of the Facility on these and a comparison of how current data compared to past data. It also reported that the diabetic educator began trending this incidence as related to time of day as a next step in identifying

obstacles to improvement (and, presumably, means to address those obstacles). This kind of approach should provide a model for reviewing and addressing health status issues.
    - The Facility had taken actions to improve on both timeliness and comprehensiveness of assessments. Although these actions were still in early stages, there was some evidence of improvement in timeliness of annual assessments.
    - Diagnoses were consistent with the current versions of the DSM and ICD classification systems.
    - The Facility had continued to develop systemic clinical indicators of efficacy of treatments and interventions in health care and other clinical areas. Many of these indicators had become integrated into the key indicators used by the Facility for quality review.

- Improvements Needed
    - Assessments in response to changes in status remained variable.
    - Documentation did not always include all needed information to support diagnoses, and assessments and results from X-rays, labs, or other tests in some cases indicated a diagnosis that was not listed or for which additional testing did not occur in order to confirm or rule out a diagnosis.
    - At an individual level, it was not always clear that the indicators were well-defined and were clinically justified, and that modification of treatments and interventions reflected the use of the indicators in identifying when changes in status required them.
    - Regarding policy development and implementation, the Facility needs to update its policy on medical care to reflect and operationalize revisions in DADS policy. DADS needs to complete revision of policy on minimum common elements of clinical care and needs to ensure the policy addresses all areas of clinical care.

<u>At-Risk Individuals</u>

The statewide risk assessment policy, with guidelines for rating risk, was in use at the Facility. The Facility continued to use supplementary tools that helped IDTs in the risk assessment planning process. 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.

- Positive Practices and Improvements Made
    - The Facility continued to have a very active Physical and Nutritional Management Committee. It was evident to the Monitoring Team that the work of this committee was substantive and oriented to decision-making.

- Improvements Needed
    - The Facility did not have a local policy and procedure which defined operational practices necessary to demonstrate that a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk is in place.
    - The Monitoring Team observed two ISP meetings held during the week of the review. Participation by relevant staff and use of clinical data in reviewing risk was variable.
    - The risk assessment process in place at the Facility did not always accurately assess risk and consider discipline specific clinical information when reviewing risk. Few risk ratings adequately rated the individuals on all risk categories based on supporting clinical data.

<u>Psychiatric Care and Services</u>

Progress was noted in a number of areas. Improvements in integrated care were noted via interdisciplinary work at the Polypharmacy Committee and in the Neurology Clinic. There has been a fair amount of work done to develop needed details for Medication Plans and to implement monitoring procedures to assess medication efficacy. There have been some setbacks in completing requirements for deployment of Reiss Screens across the campus, but the Facility has developed a reasonable plan to respond to the setbacks.

- Positive Practices and Improvements Made
    - All psychiatry staff were board certified or board eligible.
    - 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.
    - Reductions in unnecessary polypharmacy continue, and the PRC continues to support good interdisciplinary discussion on many aspects of overall pharmacological care.
    - 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
    - Although continued improvements were noted in the presentation of psychiatric information in the PBSP that helped clarify how medications were used as part of the overall treatment program, further work is needed in the area of presentation of psychiatric data.
    - The new procedures for medical/dental restraint were not yet fully in place. Reductions were noted in the amount of pre-treatment sedation that was used, but work remains to be done in the area of individualized action plans to help individuals participate in routine procedures without need for sedation.

- 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. Improvements were also needed in the area of case formulations.
- Medication Plans need more details in the areas of treatment alternatives and risk benefit analysis.
- Adequate presentation of treatment alternatives were not yet in place and many consents for new medication were not fully reviewed by the HRC since revised PBSPs had not been completed.

Psychological services

Observations, interviews, and record reviews were conducted on-site at DSSLC from 10/8/2012 through 10/12/2012. Record reviews continued off-site following the site visit. Based upon information gathered during the current site visit, it was apparent that the Facility had achieved substantial compliance for Provisions K.2 and K.3. Although the Facility had indicated that substantial compliance had been maintained for Provision K.8, the Facility did not provide the data necessary to support this claim.

It was quite evident that the Facility had invested considerable effort into improving services and maintaining previous success.

Unfortunately, there were areas in which the Facility was unable to achieve progress.

- Positive Practices and Improvements Made
  - The Facility continued to demonstrate improvement in the quality of both functional assessments and PBSPs. Progress also continued in relation to the ensuring psychology staff were certified in applied behavior analysis.
  - There was also ample evidence to support that the internal and external peer review at DSSLC continued to be comprehensive and effective.

- Improvements Needed
  - There was little evidence presented to indicate that the Facility was improving efforts to measure the reliability of data or ensure that PBSPs were implemented consistently and correctly.
  - The Facility continued to experience difficulty in implementing PBSPs in a reasonable amount of time.

Medical Care

The Monitoring Team noted continued, and significant, improvement in the provision of direct medical care and medical administration. In general, annual physician assessments were more comprehensive, included all known medical conditions, and included a more comprehensive action plan for each known medical condition. The current medical problem list was more complete, compared to previous reviews. Medical assessments were completed timely. Physicians have begun the process of evaluating chronic medical conditions on a quarterly basis. There has been appreciable reduction in the number of

cases of pneumonia and hospitalizations, and there have been no unusual adverse outcomes identified with recent deaths. The medical director continued to develop and implement meaningful improvement strategies, such as including an external physician who is certified in medical quality assurance to participate in the internal medical provider audit process, and contracting with a pulmonologist to provide educational training to staff and to provide direct patient care.

Continued, and more assertive, improvements are necessary to achieve compliance. Of primary concern following this review was the fact that physicians, in general, were not assertively participating in the IDT and CLDP processes, and the outcomes from not fully and meaningfully participating in these two processes was noted during this review. Follow-up to full resolution of acute medical conditions remained an outstanding issue.

- Positive Practices and Improvements Made
    - In general, annual physician assessments were more comprehensive, included all known medical conditions, and included a more comprehensive action plan for each known medical condition.
    - The current medical problem list was more complete, compared to previous reviews. Medical assessments were completed timely.
    - The Facility continued to enhance the medical provider audit process by ensuring that an external physician who was certified in medical QA performed their internal audits. Meaningful action plans were developed for medical provider audits that were assessed to be deficient, and quality assurance initiatives were developed to ensure that action plans were completed.
    - The mortality review process continued to significantly improve by the addition of an external physician who regularly attended all mortality reviews, and by ensuring a more robust review of deaths.

- Improvements Needed
    - Physicians, in general, were not assertively participating in the IDT and CLDP processes, and the outcomes from not fully and meaningfully participating in these two processes was noted during this review.
    - Follow-up to full resolution of acute medical conditions remained an outstanding issue.
    - The Facility did not provide or enable regular continuing medical education (CME) events on serious conditions that commonly occur in individuals with developmental disabilities, and in general the Facility did not provide efficacious management of such conditions.
    - Although the medical provider audit process included meaningful action plans, the action plans were not addressed timely by the provider.
    - The Facility must develop a mechanism to ensure efficient and efficacious management of clinical database elements.
    - The Facility must complete development and revision of medical care policies.

- Development of meaningful and effective clinical pathways should continue to expand to cover the more serious medical conditions that occur in individuals with developmental disabilities. The Policy and procedure for seizure management should be updated to reflect current practice standards.

Nursing Care

DSSLC continued to take steps forward that would lead to compliance with all Provisions. Numerous improvements and new processes had been put in place since the last compliance review, such as: An Assessment of Assessments to ensure that Annual Nursing Assessments were completed within 10 days of individuals annual Individual Support Plan Meetings. The revised Integrated Risk Rating Forms and Integrated Health Care Plan processes were implemented and all RN Case Managers were trained on the processes.

- Positive Practices and Improvements Made
  - 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 met compliance with the requirements of the Emergency Response Policy.
  - Ninety two percent of the RNs and 82% of the LVNs had completed the new Documentation Class taught by the State Office FNP Consultant. The assessments and documentation of individuals' nursing care was beginning to show improvement in the quality and comprehensiveness of the nursing assessments, and documentation for individuals with acute changes in status related to specific affected body systems had continued to improve since the last compliance visit.
  - The Medication Variance Policy was implemented and data was being gathered for each type of medication variance. The Medication Variance Committee was continuing to analyze data and determine how to represent it, as well as make it useful to improve medication practices.

- Improvements Needed
  - Although continued efforts had been made to improve the quality of the nursing assessments, the Section XI, overall nursing summaries need continued improvement to critically analyze clinical data for each identified nursing problem/diagnosis in order to accurately reflect whether individuals' health status was improving, maintaining, or regressing.
  - 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.

Pharmacy Services and Safe Medication Practices

The pharmacy department continues to progress towards compliance with Provision N, of the Settlement Agreement. The Monitoring Team noted improved processes for reviewing of AEDs, and medication variances. The Monitoring Team also noted continued compliance with Provisions N.1, N.4, N.6, and N7. Full compliance will require addition effort to improve on the QDRR process, ensuring that more robust reporting of AEDs, enhance the medication variance process by focusing more on medical prescribers variances. Overall, the pharmacy department continues to improve on its processes.

- Positive Practices and Improvements Made
  - Review of new medication orders, follow-up documentation by the pharmacist, and the 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.
  - Physicians had addressed all pharmacy recommendations. When the physician disagreed with the pharmacist's recommendation, the physician's action plan was documented.
  - The Facility maintained an effective drug utilization evaluation process.

- Improvements Needed
  - QDRRs were completed timely; however, in two out of six examples (33%), there was no QDRR provided for the reporting period. QDRRs reviewed were not comprehensive, did not fully address laboratory monitoring, did not effectively address polypharmacy, and did not assess efficacy of pharmacological treatment.
  - Although there has been an improvement in the timely review of MOSES and DISCUS examinations, there remains a need for better QA monitoring, and a process for change of status evaluations is not yet in place.
  - There is a need for a more comprehensive analysis of medical providers' medication variances. Meaningful action plans must be developed to address medical providers' medication variances.

Physical and Nutritional Management

Many positives were noted within this provision. DSSLC continued to take steps forward with regards to the providing of Physical Nutritional Management (PNM) Services. 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 focus more on observing all of these policies being implemented at the level of care. The PNMT continued to show adequate review of individuals on caseload but many times individuals who were having issues or had a significant history of PNM issues were not consistently provided the needed assessment or thorough review. PNMPs were noted to have become more comprehensive than previous reviews but were still lacking the comprehensiveness as it related to oral hygiene and care. Staff implementation of PNMPs, while improved, remained highly inconsistent.

- Positive Practices and Improvements Made
    - A Physical and Nutritional Management Team (PNMT) was in place 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.
- Improvements Needed
    - Staff implementation of PNMPs, while improved, remained highly inconsistent with an implementation rate below 50%. Staff was observed not implementing PNMPs and displaying safe practices that minimize the risk of PNM decline. Staff knowledge of plans was also noted to improve but remained below the level needed to master the plans in which they were responsible.
    - PNMPs were not clearly developed with input from all members of the IDT or reviewed consistently by the IDT.
    - Individuals were not provided with comprehensive assessments in response to changes in status or as part of an annual assessment. Individuals who had a significant history of PNM issues were not consistently identified and provided with the needed assessments. On a positive note, when individuals were identified as needing assessments, the assessments were comprehensively provided by the PNMT.
    - Supports regarding the areas of oral care were not comprehensively included in the PNMP.
    - 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.
    - The monitoring process lacked a consistent method to ensure inter-rater reliability. Monitors were 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.
    - An Aspiration Pneumonia/enteral Nutrition evaluation was developed which was a positive step. However, the evaluation was completed as more of a review and did not investigate root cause of issues resulting in hospitalization.
    - 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>
DSSLC continued to show overall improvement with services identified within this provision.

- Positive Practices and Improvements Made

- DSSLC had just recently implemented a new annual assessment format titled "Assessment of Current Status" in which the intent behind the new form was to provide more evidence of clinical assessment and review of identified areas of need over the past year. The Monitoring Team is hopeful that this new format will address the primary concern with the existing assessments in that they lacked comparative analysis of status and clear information regarding factors for community placement.
- An area of improvement was DSSLC's effort in responding to falls. The team has continued to respond more frequently and in a more comprehensive manner, especially over the last two reviews.

- Improvements Needed
  - Although response to falls had improved, information obtained through these assessments as well as others was not integrated as part of the ISP in a way that was meaningful and functional to the individual.
  - 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.
    - Assessments did not include discussion of potential for skill acquisition in areas such as eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning.
    - 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.
  - 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 ISP.
  - Therapy plans were not implemented as written and staff were not knowledgeable of the OT/PT plans.
  - A system did not exist that ensures staff responsible for positioning and transferring high risk individuals receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff.

<u>Dental Services</u>
Dental services has significantly improved since the last compliance review.

- Positive Practices and Improvements Made
  - The Facility maintained an effective mechanism that ensured the delivery of emergency dental services.
  - The Facility had significantly improved on ensuring that IPNs were documented in a way that non-dental staff could understand, and that the notes reflected the dental services provided to the individual.
  - The Facility obtains dental x-rays in accordance with standard of care practice.
  - The Facility completes a dental summary that clearly delineates the individual's comprehensive dental needs, including behavioral issues.

- The Facility had developed an external quality review process that enables an outside dentist to review the clinical practice of the Facility's dentists and hygienists.

- Improvements Needed
  - There is a less than adequate level of oral hygiene, and lack of fully implementing suction toothbrushing at the living area.
  - Of significant concern is the lack of dental office participation at the annual IDT, and CDLP meetings.
  - The QA process did not assess for potential adverse outcomes following dental services.
  - The Facility must update or develop policies and/or procedures to clearly delineate all dental practices.

Communication

Overall, the comprehensiveness of the Speech Assessments continued to improve but still lacked information regarding how communication strategies or programs could be implemented consistently and integrated throughout the day and throughout multiple tasks. Implementation of communication programs remained extremely low and staff knowledge of how to form effective communication with the individuals was not evident at the home level.

- Positive Practices and Improvements Made
  - DSSLC has filled all of their positions.
  - A communication master plan outlines the process for completing assessments.

- Improvements Needed
  - There remains a lack of the SLPs' presence in all facets of care in which their expertise was needed.
  - Individuals identified as having decreased communication did not have their plans implemented as written or throughout the day in which opportunities for increased communication were presented.
  - AAC devices were not consistently portable, functional or available in a variety of settings.
  - DCPs interviewed were not knowledgeable of the communication programs.
  - DSSLC needs to have a comprehensive monitoring system that covered the presence and condition of the device, implementation of the device, as well as SLP participation in care.

Habilitation, Training, Education, and Skill Acquisition Programs

Although there were areas of progress, the documentation provided by the Facility made it difficult to assess for several provisions the amount of progress toward compliance.

- Positive Practices and Improvements Made

- Although engagement varied greatly across settings, DSSLC had improved in ensuring that individuals were provided with meaningful activities since the last compliance visit, returning to levels found during the September 2011 visit.
- The Facility reported that arrangements had been made for a BCBA to provide training and monitoring services related to skill acquisition programs. The consultant BCBA had only just begun providing services, so it was not possible to measure specific benefits. Nevertheless, it was noteworthy that the DSSLC had arranged for assistance in this area.

- Improvements Needed
  - It was not possible for the Monitoring Team to determine progress toward compliance for several Provisions in Section S due to the need for complete and accurate supporting evidence.

<u>Most Integrated Setting</u>
Although only Provisions T1c2 and T4 were found in substantial compliance, there were many areas of improvement noted.

- Positive Practices and Improvements Made
  - Transition staffing was in the process of being augmented by two new Transition Specialist positions, which should enhance education and awareness of community living options as well as increase the pace of transitions once a referral is made.
  - The Facility had initiated a project to enhance both timeliness and adequacy of assessments to address one of its most significant deficiencies that appeared to hold promise for improvement in this area.
  - DSSLC had developed a protocol to be followed that 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.

- Improvements Needed
  - DSSLC 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 their specific learning needs.
  - There were 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.
  - CLDPs did not adequately reflect the protections, services and supports an individual would need to make a successful transition to community living.

<u>Consent</u>
Although neither provision yet is in compliance, there was noted progress on both.

- Positive Practices and Improvements Made
    - The Facility maintained 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. This strategy held promise for contributing objectivity to the prioritization process and should be reviewed by DADS for its potential statewide applicability.
    - The Facility was to be commended for its continuing 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.
    - The Facility continued training and using the expanded Rights Assessment, The Facility continued to provide support for self-advocacy and had begun using some formal choice-making materials as a part of its self-advocacy activities. The Facility also continued to develop its capacity to provide advocates for individuals as an alternative to guardianship.
    - A new DADS policy on Self-Advocacy had recently been issued, and DSSLC did continue to provide support for self-advocacy, including incorporation of the use of some formal choice-making curriculum.

- Improvements Needed
    - The new DADS 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 continued training and using the expanded Rights Assessment, but an evaluation of the instrument's application as a standardized tool for assessing decisional capacity remained to be accomplished. The IDTs continued to rely almost solely on their own subjective assessment of capacity, with no objective standardized criteria.

<u>Recordkeeping and General Plan Implementation</u>
The Facility had continued to make progress toward compliance, in terms of maintaining a unified record, auditing the record for compliance, making use of the records, and developing or revising policies needed to implement the Settlement Agreement. Improvements remain to be made in all provisions.

- Positive Practices and Improvements Made
    - The Unified Record contained all required components. Records were in generally good condition, were accessible and secure, included most documents, and were legible. There were no examples of torn pages or missing tabs, tabs were in the correct order, and all pages were readable.
    - Since the last visit, a competency test was added to the training for new employees.

- The Facility had a process to notify responsible staff of the need for corrective actions based on audit findings. Review of follow-up emails showed consistent follow-up until each correction was completed.
- Clinicians and QDDPs could describe how they used the records to make decisions and could give examples of doing so.

- Improvements Needed
  - Although Active Records contained most required documents, but neither record reviewed in detail by the Monitoring Team included all required documents; data for this small sample of two records was reasonably consistent with the trends data reported by the Facility.
  - Many assessments were not posted timely to the Share Drive or filed timely into the Active Record.
  - Although the corrective action process included consistent follow-up to ensure corrections were completed, it did not include a tracking process that could provide information on corrections still open across individuals or on the types of deficiencies that had been found. Corrective actions on individual records had not yet resulted in reducing reoccurrence of the same errors.
  - Records were not always used in provision of services and supports.
  - Although records were present at meetings, and information from records was frequently referenced, there were also examples in which impressions or interpretations of data were reported rather than data or other information from the records.
  - Both DADS and the Facility had continued to develop and revise policies but not all requirements of the Settlement Agreement have yet been addressed.
  - The Facility needs to develop procedures to ensure staff are informed and understand newly developed and revised policies and that these policies are implemented accurately.

The comments in this executive summary were meant to highlight some of the more salient aspects of this status review of the Facility. The Monitoring Team hopes the comments throughout this report are useful to the Facility as it continues to work toward meeting the requirements of the Settlement Agreement.

| SECTION C: Protection from Harm-Restraints | |
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| 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:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment 9/24/12<br>2. DSSLC Action Plan 9/24/12<br>3. DSSLC Presentation Book (undated)<br>4. DADS Policy 001.1: Use of Restraint 4/1/12<br>5. DSSLC Policy CMGMT-20 Use of Restraint 6/1/12<br>6. DSSLC Policy CMGMT-24 Dental Services Procedure: Desensitization 12/15/11<br>7. PMAB Training Curriculum (undated)<br>8. Training Curriculum for RES0105 (Restraint: Prevention and Rules for Use at MR Facilities) and RES0110 (Applying Restraint Devices) undated<br>9. Nursing Responsibilities Related to Restraints – Guidelines 2/16/12<br>10. Sample of staff training records (Sample C.2)<br>11. Restraint log for crisis intervention restraints 4/1/12 to 10/8/12<br>12. Restraint log for medical restraints 4/1/12 to 10/8/12<br>13. Restraint log for protective mechanical restraints 4/1/12 to 10/8/12<br>14. 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 Individuals #537 (8/20), #127 (5/12), #119 (6/22) and #667 (5/12)<br>15. Restraint documentation files for sample (Sample C.3 and J.2) of medical restraint for Individuals #171 (5/9), #123 (6/26), #345 (8/31), #684 (8/23), #37 (7/9), #90 (6/29), #196 (7/23), #474 (6/20), and #183 (5/14)<br>16. Documentation for Individual #537 who was restrained more than three times in a rolling 30-day period.<br>17. List of Restraint Monitors 9/23/12<br>18. DSSLC Restraint Monitoring training material 2/10/12<br>19. List of individuals injured during restraint 4/1/12 to 9/23/12<br>20. Restraint Trend Analysis 8/12<br>21. Restraint Reduction Committee minutes 5/10/12, 6/18/12, and 7/20/12<br>22. DADS Report MHMR0102 Percent of All Employees Completing Courses of Training Program 9/1/12<br>**People Interviewed:**<br>1. Jill Wooten, BCBA, Section C Lead<br>2. Ken Horstman, Director of Residential Services<br>3. Ten Direct Care Professionals (DCP's) at Timberhill Unit<br>**Meetings Attended/Observations:** |

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| | 1. Incident Management Review Team (IMRT) 10/11/12<br>2. Restraint Reduction Committee 10/10/12<br>3. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 10/9/12 |
| | **Facility Self-Assessment:**<br>DSSLC's self-assessment was generally well done usually using data review to draw compliance conclusions. The Facility's self-assessment process was thorough and detailed. It included policy review, review of Restraint Reduction Committee meeting minutes, review of Unit and Facility Incident Management Team (IMRT) meeting minutes, data from its SA monitoring tools, data developed and presented to the Quality Assurance/Quality Improvement (QA/QI) Council, and data developed and analyzed by the Behavioral Services Department.<br><br>The Facility reported that Provisions C.2 and C.8 were in substantial compliance with the Settlement Agreement (SA) and the review conducted by the Monitoring Team came to the same conclusion. 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. Interestingly, for the most part the specific findings of the Monitoring Team in each Provision mirrored the findings that the Facility reported in its self-assessment.<br><br>The Facility's Action Plan reflected action steps already taken and action steps initiated since the last review to move toward compliance with the Settlement Agreement. For example, one recently initiated action step was to train nursing staff to competency on the fundamental aspects of restraint. Another was to update the Restraint Audit Tool used by the Facility and adjust the supporting data base accordingly. 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:**<br>The Facility had made continued progress in achieving compliance in Section C. One additional Provision was in compliance and several more are close to compliance. As noted in the last several reports the major barrier to additional compliance was various aspects of the administration and monitoring of medical restraints.<br><br>The Facility had revised its restraint policy CMGMT-20 to reflect the requirements of the new State policy. Implementation was well underway.<br><br>The Facility conducted routine auditing of restraint documentation, using standardized monitoring tools.<br><br>The use of crisis intervention restraint at the Facility remained low. Since the last review, crisis intervention restraint was used only 17 times with eight different individuals.<br><br>The frequency of use of crisis intervention restraint had steadily decreased over the last several review periods. The decrease in crisis intervention restraint suggests the Facility had taken proactive steps to provide effective supports, and, that these measures have continued. The Facility is to be commended for |

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| | reducing the use of crisis intervention restraint, and sustaining this reduction over time.<br><br>The Facility's Restraint Trend Report (8/31/12) did not report any longitudinal data on the use of medical restraint. While the Restraint Trend Report did not include longitudinal data on the use of medical restraint, a review of the log presented by the Facility in response the Monitoring Team's document request suggests the use of medical restraint had increased significantly, while the development of treatments and strategies to minimize the use of medical restraint has lagged. The Facility needs to be more proactive in developing treatments and strategies that can be used to minimize the need for medical restraint.<br><br>In its last report the Monitoring Team noted that restraint documentation had improved. This continued to be the case.<br><br>With respect to implementation of the new policy addressing protective mechanical restraint for self-injurious behavior two significant problems were noted:<br>1. The Primary Care Physician (PCP) did not document that the intensity and frequency of the self-injurious behavior presented imminent risk of serious physical injury.<br>2. Monthly IDT reviews did not include a reevaluation by the PCP that the intensity and frequency of the self-injurious behavior warranted continuation of the restraint plan.<br><br>As in past reviews, inconsistent restraint monitoring by nursing staff was noted and needs to be aggressively addressed.<br><br>A 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 three reviews. Some progress has been made but much more is needed.<br><br>Policies, procedure, and documentation systems for crisis intervention restraint use were in place and for the most part require only continued vigilance through the Facility's monitoring process to achieve compliance.<br><br>All required staff training (for staff in general, and specifically for staff acting as Restraint Monitors) had been completed.<br><br>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.<br><br>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 provided structured programs for seven individuals but was able to provide plans that addressed this requirement for only two individuals. |

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| | Facility policy prohibits prone restraint and this prohibition is reinforced through staff training. The Monitoring Team review of restraint records, restraint reduction committee minutes, and minutes of the Incident Management Review Team (IMRT), did not discover any use of prone restraint.<br><br>In assessing medical conditions to be considered in the context of restraint the Annual Physician Summary often reported "based on (name of a specified medical condition) IDT should consider the risk/benefit in determining if restraint should be used in an emergency situation and put in place any safeguards to minimize the risk." There was no evidence that IDTs reviewed or acted upon the physician's recommendation. |

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| C1 | Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used. | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision.<br>1. Review of current policy Use of Restraint (CMGMT-20) for compliance with the settlement agreement.<br>2. Review of monthly restraint audit compliance results for the months of April 2012 through July 2012.<br>3. Review of the facility Quarterly Quality Assurance/Quality Improvement (QA/QI) data for restraint.<br>4. Review of the facility Restraint Trends analysis report for the months of April 2012 and May 2012.<br>5. Review of Incident Management Review Team (IMRT) meeting minutes for the months of April 2012 through August 2012.<br>6. Review of Restraint Reduction Committee meeting minutes for the months of April 2012 through August 2012.<br><br>From its self-assessment the Facility determined that:<br>1. Use of Restraint Policy CMGMT-20 (and corresponding exhibits) indicates the policy is in compliance with the components listed in Provision C.1. The Use of Restraint Policy is a new policy implemented on 06/1/12.<br>2. Compliance results for restraint audits conducted during the months of April through July 2012 were reviewed. 100% of Crisis Intervention Restraints (which includes Crisis intervention restraint for individuals with and without a restraint plan) was conducted each month. Two individuals receive Protective Mechanical Restraint for Self-injurious Behavior (SIB) and these restraints occur daily, each month. For these two individuals, two restraints are randomly selected for auditing each month. The standardized restraint audit tool does not lend itself to a thorough review of medical/dental chemical (only) restraint. Therefore, chemical/sedation (only) restraints are not included in the samples using the standardized audit tool. Samples sizes varied (from as few as 5 to as many as 23 | Noncompliance |

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| | | each month based on the frequency of occurrence of Crisis Intervention Restraint and Medical/Dental Mechanical Restraint.<br>The restraint audit compliance scores for the months of April through July 2012 for Provision C.1 are 87%, 92%, 100%, and 100% respectively. The one trend noted in April and May 2012 audits was the documentation issues of the recording of shift change information on medical mechanical restraint for two individuals. On-the-spot training was provided and improvements were noted just before the discontinuation of the restraints. All other elements of C.1 did not note any consistent problems or increasing trends since June 2012.<br>3. QA/QI data for the quarter was reviewed on 6/26/12 for Section C audit compliance results. Issues noted during this quarterly review included documentation errors and/or missions. The area in which most errors occurred were in the shift overlap exchange of information related to a specific individual's, ongoing medical mechanical restraint. Staff working with this individual received on-the-spot training to reduce errors. Results indicated ongoing training for documentation errors does reduce errors. There was no indication within QA/QI data that any prone restraints were implemented and only approved restraints were implemented. Restraint audit compliance scores for the quarter indicate no increasing trend in elements of Provision C.1 with the exception of documentation of shift overlap information as discussed above.<br>4. The facility Restraint Trends report indicates there has been no occurrence of prone restraint and only approved restraint techniques have been implemented. Only April and May 2012 data is able to be reported at this time due to the change in restraint data entry in a new Avatar (Avatar 2) data entry system. April and May 2012 Restraint Trends data reflect a decrease in Crisis Intervention Restraint that remains low in frequency and is stable at a low rate. This is likely a good indication that crisis intervention restraint is being used as stated in Provision C.1.<br>5. Review of IMRT meeting minutes for the months of April through August 2012 indicates there has been no occurrence of prone restraint and that only approved restraint techniques have been used.<br>6. Restraint Reduction Committee minutes for the August 2012 meeting included the discussion and review of noted problems with process and documentation of medical/dental chemical (sedation) restraint. Informal review included verbal feedback from nursing staff and behavior services staff. It is a current recommendation to develop an internal audit tool that more thoroughly captures process and documentation errors/omissions.<br><br>Based on the findings from this self-assessment, this provision is not in substantial compliance. Restraint audit compliance results indicate high levels of compliance for Crisis Intervention and Protective Mechanical for SIB restraints but the results do not | |

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| | | include a representative sample of medical/dental restraint. Therefore, without monitoring data for medical/dental restraint it is unclear if all procedures are being consistently implemented, specifically in regards to medical/dental restraint.<br><br><u>Monitoring Team Findings:</u><br>DADS issued a substantial revision to its statewide Restraint Policy on 4/10/12. Instructions and training material was provided to each Facility. Facilities were encouraged to phase in implementation of the requirements of the new policy in an orderly manner as staff was trained. Consequently, there was not a firm implementation date from which the Monitoring Team could assess compliance with the new policy.<br><br>As reported in the Facility self-assessment the DSSLC revised its restraint policy to meet the requirements of the revised State policy with an effective date of 6/1/12. Consequently, for this review restraints which occurred before 6/1 will be reviewed against the requirements of the old policy and restraints which occurred after 6/1 will be reviewed against the requirements of the new policy.<br><br>The major changes represented in the new policy included:<br>• Replacing one Restraint Checklist with three (one for crisis intervention restraint, one for medical/dental restraint, and one for protective mechanical restraint for self-injurious behavior).<br>• Adding a psychology department review component to the Face-to-Face Assessment/Debriefing form.<br>• Establishing a requirement for an ISP Action Plan, which is intended to decrease and ultimately eliminate the use of restraint for the individual. Action Plans. Factors listed in the policy that require development of an ISP action plan or review of an existing plan include the following:<br>a. There have been more than three crisis restraint episodes in a rolling 30-day period.<br>b. There is a consistent pattern of injuries to the individual or others as restraint procedures are carried out.<br>c. Restraint use has not decreased over time and is likely to continue unless an ISP action plan is implemented or an adjustment is made in the current ISP action plan.<br>d. The characteristics of the individual (e.g., strength, size, etc.) or changes in contraindications require that standard restraint procedures be adapted to meet his or her specific needs.<br>e. An individual has persistent self-injurious behavior, and intensive supervision and implementation of the PBSP have not sufficiently reduced the potential for imminent physical harm. | |

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| | | f. An individual's behavior is making it difficult if not impossible to provide needed medical or dental treatment or is inhibiting or undoing medical or dental treatment.<br>g. The ISP action plan has been effective in greatly reducing the use of restraints, and thus the plan, including staff instructions on the use of restraint procedures, needs revision.<br>• Establishing a new restraint category for "protective mechanical restraint for self-injurious behavior" which is described in the policy as "a type of mechanical restraint applied prior to the individual engaging in self-injurious behavior for the purpose of preventing or mitigating the danger of the self-injurious behavior".<br>• Establishing a requirement for a "Protective Mechanical Restraint Plan for Self-Injurious Behavior" which is described in the policy as a component of the ISP action plan and provides instructions for staff on how to effectively and safely apply the protective mechanical restraint, including a description of the individual's self-injurious behaviors, and instructions on when to apply and remove the restraint. The plan must identify: (1) any low-risk situations when the restraint may be safely removed and what staff should do during those situations to continue to protect the individual from harm; and (2) adjustments in staff instructions as progress is made for gradually eliminating the use of the restraints.<br>• Establishing detailed operational requirements associated with the use of protective mechanical restraints for self-injurious behavior.<br><br>The Facility reported that the requirements of the revised policy associated with crisis intervention and protective mechanical restraint for self-injurious behavior (SIB) restraint had been implemented as of 6/1/12. The Monitoring Team found this, for the most part, to be the case. The Facility reported that the requirements of the revised policy associated with medical restraint (both for dental and medical procedures) had not as yet been fully implemented. The Monitoring Team found this, for the most part, to also be the case.<br><br>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.<br><br>The use of crisis intervention restraint at the Facility remained low. As noted below crisis intervention restraint was used 17 times with eight different Individuals since the last | |

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| | | review. In the previous five month period (November 2011 through March 2012) crisis intervention restraint was used 28 times. This was an impressive reduction in restraint utilization of 39%. | |

| Type of Restraint | Date Range | Date Range |
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| | 4/1/12 to 8/31/12 | 11/1/11 to 3/31/12 |
| Personal restraints (physical holds) during a behavioral crisis | 16 | 28 |
| Chemical restraints during a behavioral crisis | 1 | * |
| Mechanical restraints during a behavioral crisis | 0 | 0 |
| TOTAL restraints used in behavioral crisis | 17 | 28 |
| TOTAL individuals restrained in behavioral crisis | 8 | * |
| Of the above individuals, those restrained pursuant to a Safety Plan | 0 | * |

*data not reported on the Facility Trend Report

The frequency of use of crisis intervention restraint had steadily decreased over time. The Facility averaged nine crisis intervention restraints per month in FY10, six per month in FY11, and five per month in FY12. In the last quarter of FY12 the average number of crisis intervention restraints was only 2.3 per month. The Facility is to be commended for reducing the use of crisis intervention restraint, and sustaining this reduction over time.

The decrease in crisis intervention restraint suggests the Facility had taken proactive steps to provide effective supports. Additional information on this topic 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.

The Facility's Restraint Trend Report (8/31/12) did not report any longitudinal data on the use of medical restraint. This was reported to be the result of certain system changes

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| | | that had occurred in June, 2012. In its last report the Monitoring Team reported that the use of medical restraint (pre-treatment oral sedation) had decreased by 20% when comparing five month periods (40 restraints per month reduced to 32 per month). While the Restraint Trend Report did not include longitudinal data on the use of medical restraint, a review of the log presented by the Facility in response the Monitoring Team's document request suggests the use of medical restraint had increased significantly. The log reporting use of medical restraint (pre-treatment oral sedation) showed 188 instances of medical restraint between 4/1/12 and 8/31/12, an average of 38 per month. This is an increase of 19%. The Facility needs to be more proactive in developing treatments and strategies that can be used to minimize the need for medical restraint. In this regard, the Facility reported it had hired a psychology assistant specifically for this purpose. The Monitoring Team looks forward to reviewing progress in this area at its next review.<br><br>A sample of crisis intervention restraint episodes, referred to as Sample C.1, was selected. The source document used for the sample was the listing of restraints used since the last review. The sample included four individuals and four restraint episodes, representing 20% of crisis intervention restraint episodes since the last review. Two restraints occurred prior to 6/1/12 and two occurred after 6/1/12.<br><br>A separate sample was selected for medical restraints.<br><br>The Facility prepared a documentation file for each restraint episode in the sample. This was to include the Restraint Checklist, Face-to-Face Assessment/Debriefing document, any restraint related medical orders, documentation of restraint review activity, and any other information thought to be helpful in understanding the circumstances associated with the restraint use such as the Individual's Positive Behavior Support Plan.<br><br>The Facility had two individuals who regularly used protective mechanical restraint for self-injurious behavior. The Monitoring Team reviewed both, applying the requirements of the revised restraint policy in this assessment. Discussion of the Monitoring Teams review is reported under Provision C.3.<br><br><u>Prone Restraint</u><br>Facility policy prohibits prone restraint and this prohibition is reinforced through staff training. The Monitoring Team review of restraint records, restraint reduction committee minutes, and minutes of the Incident Management Review Team (IMRT), did not discover any use of prone restraint.<br><br><u>Other Restraint Requirements</u><br>State and Facility policy states that restraints may only be used: if the individual poses an | |

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| | | 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.<br><br>Crisis intervention restraint records were reviewed for Sample C.1 that included the Restraint Checklist and the Face-to-Face Assessment and Debriefing Form. In its last report the Monitoring Team noted that restraint documentation had improved. This continued to be the case. For the most part, information presented on these documents accurately reported the circumstances associated with the restraint episode.<br><br>The Facility Section C Monitoring Report presented compliance rates for Provision C.1 averaging 95% over the most recent four month period. This represented a significant improvement from the 79% average previously reported. Most impressive was the reported compliance rate of 100% for the two most recent months, June and July, 2012.<br><br>The following are the results of the review by the Monitoring Team for the restraint sample:<br><br>In four of four records in the sample (100%), there was documentation showing that the Individual posed an immediate and serious threat to self or others.<br><br>In four of four 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) form and the narrative descriptions on the Restraint Checklist.<br><br>It can be difficult for the Monitoring Team to determine if restraint was or was not used for the convenience of staff or in a clinically justifiable manner. Assessment is made primarily by determining if the correct box was checked on an FFAD, by drawing conclusions from certain data reported on a Restraint Checklist and the FFAD, and, any post restraint review conducted by the Behavioral Services Department. It is possible that restraint may on occasion be inadvertently used for the convenience of staff or not in a clinically justifiable manner. This could occur when a Positive Behavior Support Plan (PBSP) had not been effective and needed changes were not being addressed in a timely manner. As reported in section K the DSSLC continued to make improvements in behavioral programming. These continued improvements, along with the data presented earlier in this report, 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 | |

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| | | 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.<br><br>In four of four 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.<br><br>One individual was the subject of emergency chemical restraint since the last review and was included in the sample. All required elements of restraint documentation were present in this case, including the Administration of Chemical Restraint Consult and Review, the Human Rights Committee review and emergency rights restriction, and the post-Restraint review by the psychiatrist and pharmacist.<br><br>Facility policies identify a list of approved restraints. All restraints reviewed by the Monitoring Team were policy-approved restraints.<br><br>The Monitoring Team sample of crisis intervention restraints found a high degree of compliance with this provision. In fact, if the subject matter of this Provision directed itself only to crisis intervention restraint the Facility would likely be in substantial compliance. The Monitoring Team identified substantive compliance issues with the use of medical restraint. These are described in Provision C.4 and impact compliance with Provision C.1. The Facility self-assessment also identified this problem as the primary reason for its self-assessment rating of noncompliance. The Monitoring Team also identified substantive compliance issues with policy requirements associated with the new restraint category for protective mechanical restraint for self-injurious behavior. These are described in Provision C.3 and impact compliance with Provision C.1. 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. | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Review of monthly restraint audit compliance results for the months of April 2012 through July 2012.<br>2. Review of the facility Quarterly Quality Assurance/Quality Improvement (QA/QI) for restraint.<br><br>From its self-assessment the Facility determined that:<br>1. Compliance ratings for Provision C.2 for the months of April through July 2012 were 100%, 86%, 100%, and 100% respectively. Two issues were noted in these | Substantial Compliance |

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| | | audits. One issue was noted in the May restraint audit related to medical mechanical restraint in which checklists were not immediately available to an auditor at the time of her audit. There has been no other occurrence of unavailability of restraint documentation for restraint audits. The other issue noted during the May 2012 audit was that the auditor's did not score C.2 completely correct. Review of Face-to-Face de-briefing forms indicated the person was released when no longer dangerous to self or other but the restraint checklist indicated the staff could no longer hold the individual safely and released them. The Restraint Auditor should have marked this element "no". Auditors are notified of errors and this reduces such errors. Restraint Monitors did receive training on how to document on this element correctly in May 2012 during training of the new restraint policy. Other than audits indicating this problem in June, no additional problems or trends were identified in following months. Monthly restraint audit data reviewed in July reflected 100% compliance with terminating restraint as soon as the individual is no longer a danger to self or others. This was accurately documented on the crisis intervention restraint checklist and on the face to face de-briefing form.<br>2. Quarterly QA/QI data reflects similar results as those found in the monthly restraint audits as discussed above. The one issue identified was lack of available restraint checklists during audits of a medical mechanical restraint. This occurred during just one month's audits.<br><br>Based on the findings from this self-assessment, this provision is in substantial compliance evidenced by high levels of compliance with restraints being terminated when an individual is no longer a danger to self or others. 100% audit of Crisis Intervention Restraints, in which restraints are released for no longer being a danger to self or others, have had compliance ratings of 100% for Provision C.2 since June 2012.<br><br><u>Monitoring Team Findings:</u><br>Three of the four restraints in the sample were physical restraints. The fourth restraint was a chemical restraint. The duration of the three physical restraints was one minute, three minutes, and three minutes. A review of restraint records indicated restraint was terminated as soon as the individual was no longer a danger to him/herself or others. Additionally, the Facility's monitoring data also reported a high degree of compliance.<br><br>This Provision is in substantial compliance. | |
| C3 | Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Review of monthly restraint audit compliance results for the months of April | Noncompliance |

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| | one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint. | 2012 through July 2012.<br>2. Review of the facility Quarterly Quality Assurance/Quality Improvement (QA/QI) data for restraint.<br>3. Review of the facility training report for the classes of RES0105, RES0110, PMA0320, PMA0400, PMA0700, PBS0100 (which include approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint) which would meet the competency based training in regards to applying restraint per the criteria listed in Provision C.3.<br>4. Review of the facility Restraint Trends analysis report for the months of April 2012 and May 2012.<br>5. Review of IMRT meeting minutes for the months of April 2012 through August 2012.<br><br>From its self-assessment the Facility determined that:<br>1. Monthly restraint audit compliance results for the months of April 2012 through July 2012 indicate only one occurrence of a direct contact staff member (who participated in the implementation of a restraint) not being current in required training related to restraint. This was just one staff out of all sampled restraints since April 2012. This individual and their supervisor were notified of the need to complete training. No addition action plans were needed to address this issue. Audit results reflected that sampled restraints were approved restraints and that the restraints audited used the least restrictive intervention necessary to manage behaviors.<br>2. The review of QA/QI data for the quarter also reflected there was only one occurrence of one staff member who was not current in required restraint training. Similar results were noted during monthly restraint audits as described above.<br>3. Facility training compliance percentages for courses RES0105 (Restraint: Prevention and Rules for Use at MR Facilities, RES0110 (Applying Restraint Devices), PMA0320 (PMAB Basic, PMA0400 (PMAB Restraint), PMA0700 (PMAB Prevention), and PBSP0100 (Positive Behavior Support) have remained at completion percentages of 98% or higher, for each course listed, for every month since the last review through August of 2012.<br>4. Facility Restraint Trends Analysis reports for April and May 2012 indicate that only approved restraints were implemented.<br>5. IMRT meeting minutes for the months of April through August 2012 indicate that only approved restraints, per restraint policy, were implemented.<br><br>Based on the findings from this self-assessment, this provision is not in substantial compliance. While substantial compliance is noted in the training component of this | |

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| | | provision, problems noted in Provision C.1 in regard to implementation of restraint documentation for medical/dental restraint indicate a need for improvement in this area before substantial compliance can be obtained in Provision C.3.<br><br><u>Monitoring Team Findings:</u><br>The Facility's policies and implementation activity related to restraint are also discussed, in part, in Provision C.1 and C.4.<br><br>Protective mechanical restraint for self-injurious behavior policy implementation: The Facility had two Individuals using protective mechanical restraint for self-injurious behavior. Both had used this form of restraint for an extended period of time prior to the implementation of the revised State and Facility policy. The Monitoring Team reviewed documentation requirements associated with the revised restraint policy for both Individuals and the findings of the Monitoring Team were the same for both Individuals. Because this was an initial review using the revised policy requirements the review consisted primarily of determining whether policy-required information was present in the documentation provided to the Monitoring Team. For both individuals the Monitoring Team determined:<br>• The individuals each had a Protective Mechanical Restraint Plan that included person-specific instructions, and staff had been trained in these instructions.<br>• The IDT for both individuals had developed an ISP Action Plan that described the need for restraint, described the restraint procedure, included a Positive Behavior Support Plan (PBSP), and described conditions under which restraints could be safely removed.<br>• A Structural Functional Assessment had been completed.<br>• There were not documented Primary Care Physician (PCP) determinations for either individual that described the intensity and frequency of the self-injurious behavior that led to a determination by the PCP that without the restraint the Individual would be at imminent risk of serious physical injury.<br>• Monthly IDT reviews did not for either individual document a continued reevaluation by the PCP as to whether the intensity and frequency of the self-injurious behavior warranted continuation of the restraint plan. This is not intended to mean that physician review alone is adequate for determination of the need to continue the restraint plan but that the PCP must indicate whether there is continuing imminent risk without the use of protective restraint and whether the plan does protect the individual adequately. This will be especially important as the plan is modified to address reduced risk and improved behavior leading toward reduced duration or intrusiveness of restraint.<br><br>Some of the required information described above was gleaned from Individual Support | |

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| | | Plans (ISPs), Individual Support Plan Addendums (ISPAs), and related documents. For instance, there was not a document labeled "Protective Mechanical Restraint Plan" but it was clear that narrative contained in an ISP and/or an ISPA sufficiently addressed the topics required by policy.<br><br>Finally, a review of nursing requirements associated with protective mechanical restraint for self-injurious behavior revealed several issues as noted below.<br><br>Based on a review of two protective mechanical restraint for self-injurious behavior records for a recent two week period there was documentation that a licensed health care professional:<br>▪ In zero of two (0%) records, daily completed at least one on-site observation of individuals while the protective mechanical restraints were being used and documented whether the protective mechanical restraints were applied properly and whether their application matched the individuals' Protective Mechanical Restraint Plans for Self-Injurious Behavior.<br>o Individual #336's daily use of protective mechanical restraint was observed and documented on-site in 10 of 14 (71%) days.<br>o Individual #381's daily use of protective mechanical restraint was observed and documented on-site in nine of 14 (64%) days.<br>▪ In one of two (50%) records, daily documented individuals' vital signs, mental status, and any injuries on the Protective Mechanical Restraint Checklist (DSSLC CMGMT-C).<br>o Individual #381's daily vital signs, mental status, and any injuries were assessed and documented on the Protective Mechanical Restraint Checklist (DSSLC CMGMT-C) in 13 of 14 (93%) days.<br><br><u>Staff Training</u><br>Review of the Facility's training curricula revealed that it included adequate training and competency-based measures in the following areas:<br>1. Policies governing the use of restraint;<br>2. Approved verbal and redirection techniques;<br>3. Approved restraint techniques; and<br>4. Adequate supervision of any individual in restraint.<br><br>DSSLC Policy CMGMT-20 (6/10/12) Use of Restraint did 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 second 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:<br>1. RES0105 Restraint: Prevention and Rules for Use at MR Facilities | |

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| | | 2. RES0110 Applying Restraint Devices<br>3. PMA0320 – PMAB Basic<br>4. PMA0400- PMAB Restraint<br>5. PMA0700 –PMAB Prevention<br>6. PBS0100 – Positive Behavior Support<br><br>The 25 staff in the sample all (100%) completed all required training.<br><br>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:<br>1. 99% RES0105 Restraint: Prevention and Rules for Use at MR Facilities<br>2. 99% RES0110 Applying Restraint Devices<br>3. 98% PMA0320 – PMAB Basic<br>4. 98% PMA0400- PMAB Restraint<br>5. 99% PMA0700 –PMAB Prevention<br>6. 99% PBS0100 – Positive Behavior Support<br>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.<br><br>The Monitoring Team met with 10 Direct Care Professionals (DCPs) from an active residential area and asked two restraint related questions. The first question was "from the training you've received describe some strategies you would use with an individual whose behavior may lead to restraint." One member of the Monitoring Team, one Facility QA staff, and one Facility administrator independently scored the responses. Therefore for each question there were 30 possible acceptable or unacceptable responses. Only 53% of the responses to this question were determined to be acceptable. The second question was "if you are involved in restraint what other staff would typically be with or near you to assist?" Only 83% of the responses to this question were determined to be acceptable. The Facility may wish to routinely conduct competency checks of staff knowledge to ensure training received is retained.<br><br>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 associated with medical restraint (refer to Provisions C.1 and C.4) and protective mechanical restraint for self-injurious behavior and reported through the Facility monitoring of restraint documentation, preclude a finding of substantial compliance with this Provision. | |
| C4 | Commencing within six months of | <u>Facility Self-Assessment:</u> | Noncompliance |

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| | the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint. | The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Review of monthly restraint audit compliance results for the months of April 2012 through July 2012.<br>2. Review of the facility Restraint Trends analysis report for the months of April 2012 and May 2012.<br>3. Review of the facility Quarterly Quality Assurance/Quality Improvement (QA/QI) data for restraint.<br>4. Review of the current list of individuals in need of treatments, strategies, or supports to reduce the need of restraint, which includes listing of completion status of treatments, strategies, and supports.<br>5. Review information from the facility Director indicating if any individuals living at the facility have restrictions or prohibitions for restraint.<br>6. Review of Restraint Reduction Committee meeting minutes from April 2012 through August 2012.<br><br>From its self-assessment the Facility determined that:<br>1. Monthly restraint audit compliance results for the months of April 2012 through July 2012 indicate 100% compliance ratings for elements of provision C.4. These results do indicate that a restraint is either a crisis intervention restraint or not and that no restraint has been prohibited by a medical order. Also, ISP's audited for those restraints sampled did not have prohibitions listed for restraint for the individuals in question. Similar issues had been noted with the annual Physician's summary review of restraint in regards to risk and need for any restrictions or prohibitions. Action plans were developed to address these two issues.<br>2. The facility Restraint Trend analysis report for April and May 2012 indicate that the use of restraint has been limited to crisis intervention, medical restraint or protective mechanical restraint as defined in the restraint policy and in accordance with Provision C.4. Review of the frequency of occurrence of medical/dental restraint indicates that the frequency of the use of medical/dental restraint, specifically sedation, is variable and is typically a function of the number of appointments and procedures scheduled per month. TIVA continues to be administered at a stable rate as individuals receive needed dental treatment.<br>3. The facility Quarterly QA/QI data reflect the same results as the monthly restraint audit compliance results as mentioned above. Additional QA/QI discussion included the Dental Directors completion of a definition system for what is considered "Routine" and "Non-Routine" procedures. This system and definitions help determine if treatments, supports, and strategies are needed for an individual. | |

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| | | 4. The current list of individuals who have been referred for review for the need for treatments, supports, and strategies to reduce the use of sedation for dental procedures indicates 39 individuals have now received a formal assessment for the need for formal desensitization procedures or informal acquisition plans. The formal assessment process by the Dental Desensitization Psychological Assistant began in April and has continued through August. The assessments process includes the At Home Assessment and Dental Assessment (form), and then if needed a Behavior Protocol conducted which determines the need for formal or informal supports. Two formal desensitization plans have been developed and implemented by the Dental Desensitization Psychological Assistant. There are currently 12 skills acquisition plans developed awaiting approvals by the individual's team before implementation can occur. Informal supports have been developed by QDDP's.<br>5. If any individuals are identified by the Physician as needing restrictions or prohibitions for restraint, the facility Director is to be notified. No individual's with specified restrictions or prohibitions for restraint have been identified.<br>6. The Restraint Reduction Committee has reviewed actions taken since April 2012 to address issues related to Provision C.4. The Considerations for Implementing Medical/Physical Restraint document to be completed by Physician's per annual meeting or as needed was implemented on 7/1/12. A combined meeting between Section C and Section F occurred which resulted in the review and update of the current ISP and Quarterly Review documents in regards to inclusion of restraint related information. A workgroup consisting of Physician's, Behavior Services staff, and Nursing met and created a list of "Routine" and "Non-Routine" medical appointments and procedures. By defining those events that would be considered "Routine" the Physician's and the IDT can more accurately determine if a person is in need of treatments, supports, and strategies to reduce the need for restraint for medical procedures.<br><br>Based on the findings from this self-assessment, this provision is not in substantial compliance due to problems noted with consistent implementation of medical/dental restraint procedures and documentation including development of treatments, strategies, and supports to minimize the use of restraint. Improvements have been made in the completion of desensitization and support plans in the area of dental procedures but considerable improvement is needed in the processes of medical restraint.<br><br><u>Monitoring Team Findings:</u><br>The Facility's policies and implementation activity related to restraint are discussed, in part, in Provision C.1 and C.3.<br><br>As reported under Provision C.1, restraint use characterized by the Facility as crisis | |

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| | | intervention was found by the Monitoring Team to be in response to an immediate safety situation.<br><br>The Monitoring Team reviewed the four crisis intervention restraint records in Sample C.1 to determine if any restraint techniques were used that were prohibited by the Individual's medical orders or ISP. The Facility's method for identifying whether restraint techniques were prohibited by the Individual's medical orders was twofold. The Annual Physician Summary template contained a required entry addressing this topic, and, a specific form titled "Considerations of Implementing Physical/Medical Restraint" was put in place as of 7/1/12. Two of the four restraints in Sample C.1 occurred after 7/1/12 and the Facility was unable to produce this form for either restraint. The Monitoring Team expects to see some type of documentation that the PCP and IDT have given thoughtful consideration to Individual's medical conditions in the context of the risk/benefit of restraint. The Annual Physician Summary template addresses this topic but often reports "based on (name of a specified medical condition) IDT should consider the risk/benefit in determining if restraint should be used in an emergency situation and put in place any safeguards to minimize the risk." This was the case in three of four restraint files in Sample C.1. In all three there was nothing to indicate the IDT reviewed or acted upon the physician's recommendation.<br><br>The Facility used protective mechanical restraint for self-injurious behavior with two Individuals. Facility compliance with the requirements of the revised Facility and State policy are discussed in Provision C.3.<br><br><u>Medical Restraint</u><br>While the Facility was further along in addressing requirements associated with medical restraint than that observed at the last review considerable additional work is needed. The Facility appears to understand the conceptual framework of the requirements of this provision but is having difficulty, as expressed in their self-assessment, in the administration of consistent implementation and documentation of required practices associated with the use of medical restraint.<br><br>The Facility had recently filled a full time position in the Behavior Services department designated to address this requirement (referred to as the "Desensitization Psychological Assistant"); however, at the time of this review the impact of this persons work had produced limited results, reporting that two dental support plans were in the process of being implemented. Finally, as reported in the last review, 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 are very likely "treatments and strategies" different from, or in addition to, desensitization that the Individual's ISP should consider in this regard. | |

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| | | The Monitoring Team looks forward to assessing progress in this area at its next review.<br><br><u>Medical monitoring of medical restraint (pre-treatment sedation):</u><br>Since the last compliance tour the Facility had shifted to the use of DADS Procedure 001.1 Use of Restraints (04/10/2012). The new procedures included a new DADS Medical/Dental Restraint Checklist. The checklist included a template that spelled out the particular time points in the procedure when vital sign and related safety checks were to be done. The Monitoring Team reviewed how nurses monitored for safety during pre-treatment restraint procedures. This was done by review of the nursing care protocols, the nursing guidelines for nursing responsibilities related to restraints, and the training of nurses for such monitoring. The latter took place during a meeting between the Monitoring Team and representatives of the Nursing Department, on 10/09/12.<br><br>The Monitoring Team confirmed that for oral pretreatment sedation, procedures for vital sign monitoring were:<br>• Prior to the procedure: Pre-medication baseline and then every 30 minutes<br>• After the procedure: Every 30 minutes x 2, then every two hour x 2, then every four hours for 24 hours.<br><br>For post anesthesia care (TIVA) monitoring was:<br>• In the recovery area (infirmary): Every 15 minutes for one hour, then every 30 minutes for one hour until a REACT score of eight is achieved. The REACT score was a measure of alertness; higher scores indicate a higher level of alertness.<br>• On the home: Every two hours x two, then every shift for 72 hours.<br><br>The Monitoring Team reviewed the 18 cases of use of pre-treatment sedation out of the roughly 450 that took place during the review period (about 4%). Only nine of 18 (50%) of the cases reviewed used the new medical/dental restraint checklist, which was put in place during the review period. These nine cases were Sample J3, and each of these sedations was reviewed. Vital signs, including baseline measurement for oral pretreatment sedation, were obtained for all individuals. Physician/Dentist orders outlining the type and frequency of safety monitoring were provided in all cases. In TIVA cases, REACT scores were obtained in the recovery/infirmary area, prior to the individual's being released to the home.<br><br>A number of problems were noted, however, and most related to monitoring for safety. Most of these were during/after TIVA procedures. For TIVA procedures, 72 hours of monitoring was required, but in three of nine (33%) cases, documentation during the latter part of that period could not be confirmed. It was difficult for the Monitoring Team to confirm that vital sign monitoring took place in the infirmary at the required intervals | |

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| | | after completion of the TIVA procedure. This may have been due in part to the way documentation took place in the recovery area which appeared to vary from case to case. In some cases infirmary documentation was listed on the old post sedation monitoring form and subsequent monitoring was on the new form. At other times, a separate sheet of infirmary information was used and it was attached to new restraint form. On yet others, Facility nurses used the new restraint form. In two of nine cases (22%), no infirmary documentation was received. In one case (Individual #684, an oral pre-treatment sedation) there was a lengthy lapse in vital sign monitoring and the protocol was apparently not followed.<br><br>The Monitoring Team tried to understand how and where the apparent breakdown in procedure occurred, and what might be done to improve the monitoring. A useful meeting took place during the visit on 10/09/12 with the nursing department and these matters were discussed. As a general observation, the Monitoring Team noted that the new medical dental restraint form was organized in a way that was intuitive and straightforward for vital sign monitoring for oral pretreatment: The restraint form provided a place for documentation of vital sign monitoring for 25 hours. There is a section for "RN/LVN Pre-Treatment Monitoring Pre-Appointment V/S = Baseline; q 30 minutes until departs location" and there is a different section for "RN/LVN Post-Sedation Monitoring post sedation VS = arrival; q 30 x2; q 2hrs x2 then q 4 hrs x 24 hrs". However, how the form should be used for TIVA was less obvious. For most (but not all) individuals who received TIVA there was no oral pretreatment sedation. The IV drugs, of course, preceded the dental treatment and were therefore still pre-treatment, but documentation of that was part of the TIVA anesthesia record and was not on the medical restraint form. It was also not clear when "post sedation" monitoring started. After the TIVA procedure, the individual was first seen in the recovery/infirmary area until stable. When the individual was determined to be stable he/she was released to the home and monitoring continued. From a standpoint of the restraint form, it was not clear whether the time for recovery in the infirmary should be considered part of TIVA procedure, or part of the post sedation period. In short, it was not clear how the nurse monitoring for safety that followed the procedure should be documented on the new medical restraint form. As a general matter, it was clear to the Monitoring Team that the new forms were not being used in a consistent matter during sedations, and that made both the provision of care and the monitoring of the care more difficult. During the visit the Monitoring Team recommended to the Facility that for TIVA procedures, guidelines should be provided to nurses about how information from the infirmary recovery area should be integrated with the new medical/dental forms. Similarly, guidelines should be provided regarding documentation of vital signs, for the period of time between the end of the medical/dental restraint form at 25 hours, and the remainder of the 72 hour monitoring period. Appropriate training on the use of the new forms should then be provided. | |

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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><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Review of monthly restraint audit compliance results for the months of April 2012 through July 2012.<br>2. Review of the facility Quarterly Quality Assurance/Quality Improvement (QA/QI) data for restraint.<br>3. Review of current training curricula for Restraint Monitors and training completion status.<br>4. Review of Restraint Reduction Committee meeting minutes for the months of April 2012 through August 2012.<br><br>From its self-assessment the Facility determined that:<br>1. Monthly restraint audit compliance results for the months of April and May 2012 were 100% and 96% respectively. There have been no individual subject to restraint away from campus since the last monitor visit. In the May 2012 audit some restraint checklists were not immediately available at the time of the audit. This was the only occurrence of lack of available checklists to be used for auditing purposes. Monthly restraint audit compliance results for the months of June and July 2012 were 67.9 and 62.5% respectively. June 2012 restraint audit compliance scores indicated improvement in conducting face to face de-briefing and nursing monitoring of vitals and mental status within 30 minutes. There were only four restraints that applied to these issues in the sample and one of them was scored "no". Nursing monitoring did occur but did not include all pieces of needed information. A stringent audit of these sections resulted in lower compliance ratings for one restraint. Problems occurred with a dental mechanical restraint related to documentation errors by dental staff. The Dental Director was notified of each type of error to then direct other dental staff in documentation. On-the-spot training with involved staff that make errors continues to reduce future errors with those staff. Compliance results for the month of July 2012 indicated problems in areas of C.5 that resulted from the late notification of occurrence of restraint (by staff implementing crisis intervention restraint) to the Restraint Monitor and Nurse. Each month, two individuals with Protective Mechanical Restraints for SIB, restraint documentation are reviewed. At this time they are the only two individuals with a Clinical Justification for Extraordinary Circumstances and monitoring per this justification is occurring.<br>2. The facility Quarterly QA/QI report indicated similar results as in the Monthly Restraint Audit Compliance results as mentioned above. | Noncompliance |

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| | | 3. Restraint Monitors have received training as they are newly hired into the position. In addition, in accordance with updated Use of Restraint policy, Restraint Monitors were provided training in May of 2012. This training is the curricula used to train Restraint Monitors. All Restraint Monitors are current in restraint monitor training.<br>4. Restraint Reduction Committee reviewed the current Order for Medical/Dental Restraint/Sedation and determined revisions are needed. Action plans were developed for a small workgroup to meet and make revisions to this order form. Use of this form on a consistent basis with appropriate prompts will improve the specification of the schedule and type of monitoring ordered by the Physician.<br><br>Based on the findings from this self-assessment, this provision is not in substantial compliance due to low compliance ratings in the elements of C.5. Compliance results indicate that processes related to the use of restraint have not been consistently implemented with a high degree of accuracy.<br><br><u>Monitoring Team Findings:</u><br>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.<br><br>The Facility provided a list of ten 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.<br>1. ABU0100 Abuse and Neglect<br>2. PMA0320 PMAB Basic<br>3. PMA0400 PMAB4: Restraint<br>4. PMA0700 PMAB7: Prevention<br>5. CPR0100 CPR Basic<br>6. RES0105 Restraint: Prevention and Rules for Use at MR Facilities<br>7. RES0110 Applying Restraint Devices<br>8. UNU0100 Unusual Incidents<br>9. PBS0100 Positive Behavior Support<br><br>The training records of six of the ten staff designated as restraint monitors were selected for review. These six staff served as the restraint monitor for the four restraints in Sample C.1 and the ongoing protective mechanical restraints for self-injurious behavior | |

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| | | of two Individuals.<br><br>Based on review of these six 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.<br><br>Based on a review of four crisis intervention restraint records (Sample C.1), a face-to-face assessment was conducted in all four incidents of restraint (100%) by an adequately trained staff member.<br><br>In four instances (100%), the documentation on the FFAD showed that an assessment was completed of the application of the restraint.<br><br>In four instances (100%), the documentation on the FFAD showed that an assessment was completed of the circumstances of the restraint.<br><br>None of the four crisis intervention restraint records in the sample indicated an alternative physician-ordered monitoring schedule. Separate from the sample there were two instances where a physician had ordered an alternative schedule of monitoring (Individuals #336 and #381). The circumstances associated with these two individuals are discussed in Provisions C.4 and C.7 of this report.<br><br>The Facility reported no instance of restraint occurring while an individual was away from the Facility.<br><br>In prior reports 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 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.<br><br><u>Nursing Review</u><br>Two of the four restraint records reviewed were completed prior to the revision of the Use of Restraint Policy CMGMT-20 (6/1/12) and two were reviewed after the policy was revised and implemented.<br><br>Based on a review of two restraint records from Sample C.1 for restraints that occurred at the Facility prior to 6/1/12, there was documentation that a licensed health care professional:<br>▪ Conducted monitoring at least every 30 minutes from the initiation of the restraint in one (50%) of the instance of restraint. | |

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| | | o Individual #667 was physically restrained on 5/12/12 at 5:30 p.m. The nurse documented that three attempts were made to monitor Individual #667 but he refused to allow monitoring and was biting. The time the attempts were made was not documented.<br>▪ Monitored and documented vital signs in one (50%). Records that did not contain documentation of this included:<br>o Individual #667 was physically restrained on 5/12/12 at 5:30 p.m. The nurse documented that three attempts were made to monitor Individual #667's vital signs but he refused to allow monitoring and was biting staff. The time the attempts were made was not documented. Although the individual refused to allow vital signs taken, the nurse should have been able to document whether or not the Individual was experiencing possible signs of distress, e.g., problems with respiration or other indicators of distress.<br>▪ Monitored and documented mental status in one (50%). Records that did not contain documentation of this included:<br>o Individual #667 was physically restrained on 5/12/12 at 5:30 p.m. The nurse documented that three attempts were made to monitor Individual #667's vital signs but he refused to allow monitoring and was biting staff. The time the attempts were made was not documented. Through observation the nurse should have been able to assess and document Individual #667's mental status.<br><br>Based on a review of two restraint records from Sample C.1 for restraints that occurred after 6/1/12 at the Facility, there was documentation that a licensed health care professional:<br>▪ Conducted monitoring at least every 15 minutes from the initiation of the restraint in two (50%) of the instance of restraint.<br>o Individual #119 was physically restrained on 6/22/12 at 1:30 p.m. The nurse did not begin monitoring until 3:45, approximately three hours after the restraint was applied.<br>▪ Monitored and documented vital signs in one (50%). Records that did not contain documentation of this included:<br>o Individual #119 was physically restrained on 6/22/12 at 1:30 p.m. The nurse did not begin monitoring vital signs until 3:45, approximately three hours after the restraint was applied.<br>o Individual #537 received a chemical restraint (Zyprexa 10mg) on 8/20/12 at 8:35 p.m. Vital signs were not consistently taken every 15 minutes as required by policy. Initially for two 15 minute intervals vital signs were refused due to extreme aggression, and the individual was allowed time to calm down. On two other 15 minute intervals he was | |

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| | | sleeping. Although Individual #537 refused to allow vital signs taken initially, the nurse should have been able to document whether or not the Individual was experiencing possible signs of distress, e.g., problems with respiration or other indicators of distress.<br>▪ Monitored and documented mental status in one (50%). Records that did not contain documentation of this included<br>o Individual #119 was physically restrained on 6/22/12 at 1:30 p.m. Although Individual #119's mental status was monitored, the nurse did not begin monitoring until 3:45, approximately three hours after the restraint was applied.<br><br>The Monitoring Team noted documentation on the Restraint Checklists of numerous refusals by the individuals to allow the nurses to complete the required vital signs monitoring. In the future, if an individual frequently refuses to allow the nurses to complete the required monitoring, this may indicate a need to do something different with the ISP, skill acquisition plan, or crisis intervention plan.<br><br>The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA. Inconsistent monitoring by nursing staff needs to be addressed. | |
| C6 | Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Review of monthly restraint audit compliance results for the months of April 2012 through July 2012.<br>2. Review of the facility Quarterly Quality Assurance/Quality Improvement (QA/QI) data for restraint.<br><br>From its self-assessment the Facility determined that:<br>1. Monthly restraint audit compliance results reviewed during the months of April through July 2012 noted problems in the data reviewed in April and May 2012. Problems noted were correctly documenting codes on the restraint checklist for two medical mechanical restraints. On-the-spot training was provided as well as on-going coaching for staff working with the two individuals receiving medical mechanical restraint. Documentation improved but minor problems are still noted. More defined procedures for Medical Mechanical Restraint were included as part of the Use of Restraint policy trainings that began in May of 2012. Monthly restraint audit compliance results reviewed in June and July 2012 indicated 100 and 83.1% compliance for elements of C.6. This was significant improvement compared to results in April 2012. It should be noted that audits did not include Medical/Dental Chemical Restraint (chemical only restraint). | Noncompliance |

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| | alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A. | The current audit tool does not adequately review chemical restraint. Audit results indicate that individuals are being checked for injury and levels of supervision have been documented. For the one individual (with Protective Mechanical Restraint for SIB) who has a Clinical Justification for Extraordinary Circumstances, for an alternate level of supervision, supervision has been provided as appropriate.<br>2. Quarterly QA/QI data indicates similar findings as those from the monthly restraint audit compliance results. The trend identified for the quarter was documentation issues related to Medical Mechanical Restraint. There were no other trends identified in restraint audits for Provision C.6 for Crisis Intervention Restraints, Protective Mechanical Restraints for SIB, and one Medical/Dental mechanical restraint for a dental procedure. An internal tool for use in auditing Medical/Dental Chemical restraint (chemical only restraint) has been recommended in efforts to provide more useful data for use of sedation.<br><br>Based on the findings from this self-assessment, this provision is not in substantial compliance. Compliance ratings decreased in July 2012 to 83.1% below the facility threshold of 85%. Compliance results have not remained consistently high indicating need for improvement.<br><br><u>Monitoring Team Findings:</u><br>In the crisis intervention restraint sample (Sample C.1) 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. Additionally, the documentation related to the two Individuals using protective mechanical restraint (see Provision C.3) also validated compliance with this Provision. 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.<br><br>A sample (Sample C.1) of four Restraint Checklists for individuals in crisis intervention restraint was selected for review. The following compliance rates were identified for each of the required elements:<br>• In four (100%), continuous one-to-one supervision was documented.<br>• In four (100%), the date and time restraint was begun was documented.<br>• In four (100%), the location of the restraint was documented.<br>• In four (100%), information about what happened before, including the change in the behavior that led to the use of restraint was documented.<br>• In four (100%), the interventions taken by staff prior to the use of restraint were | |

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| | | documented and were adequate for post restraint review.<br>• In four (100%), the specific reasons for the use of the restraint were documented.<br>• In four (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated on the restraint checklist.<br>• In four (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.<br>• The Restraint Checklist documented observations of the individual and actions taken by staff while the individual was in restraint. All three (100%) physical restraint episodes were of short duration (recorded on the Restraint Checklist three minutes, three minutes, and one minute); therefore some of the requirements of this provision (such as observations documented at least every 15 minutes) would not be applicable.<br>• In four (100%), the specific behaviors of the individual that required continuing restraint were noted.<br>• Because of the short duration of all four 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.<br>• In four (100%), the level of supervision provided during the restraint episode was recorded on the restraint checklist.<br>• In four (100%), the date and time the individual was released from restraint was recorded on the restraint checklist.<br>• In four (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.<br><br>In a sample of four records (Sample C.1), FFADs had been completed for four (100%). These forms were generally complete in checking all the required boxes on the form, supplemented with appropriate narrative. In the last review the Monitoring Team noted that the attention to detail required to complete this documentation accurately had improved. This improvement was noted to continue.<br><br>A sample of nine instances of individuals who received medical restraint (pre-treatment oral sedation or TIVA) and used the new medical/dental restraint checklist was reviewed. As noted in Provision C.4 the documentation provided to the Monitoring Team was insufficient to validate that restraint use had been adequately documented.<br><br>DSSLC Policy CMGMT-21 requires: If a health care provider or dentist orders a use of | |

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| | | restraint for medical/dental treatment the written order must include:<br>1. Type of restraint<br>2. Clinical justification for the use of the restraint<br>3. Duration of the order<br>4. The schedule and type of monitoring required<br>5. Special instructions for the individual's care, if any, while restraints are being used.<br>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.<br><br>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 one individual was placed in restraint more than three times in any rolling thirty-day period. A sample of this single individual (100%: Individual #537) was selected for review to determine if the requirements of the Settlement Agreement were met.<br><br>The following documents were reviewed<br>• ISPs,<br>• ISP addenda (ISPAs),<br>• IDT meeting minutes,<br>• Psychological Assessment/Functional Assessment report,<br>• Positive Behavior Support Plan (PBSP),<br>• PBSP progress notes,<br>• SPCIs,<br>• Physicians Orders for restraint,<br>• Restraint Checklists,<br>• Face-to-Face restraint debriefing forms<br><br>The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement.<br><br>For two of the three instances meeting the criteria reviewed (67%), the individual's team met to discuss the restraints. These meetings occurred on 4/26/2012 and 5/10/2012. The Individual met criteria for review again on 8/20/2012. There was no documentation in the record that the IDT met to review restraint following the instances on 8/20.2012. | |

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| | (a) review the individual's adaptive skills and biological, medical, psychosocial factors; | Facility Self-Assessment:<br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Review of monthly restraint audit compliance results for the months of April 2012 through July 2012.<br>2. Review of PSP addendums for inclusion of the review of the individual's adaptive skills and biological, medical, and/or psychosocial factors.<br><br>From its self-assessment the Facility determined that:<br>1. Monthly restraint audit compliance results for the months of April through July 2012 indicate that for the months of April, May, and June 2012 there were individuals that met the criteria of more than three restraints implemented in a rolling 30 day period of time. These individuals' restraints consisted of Protective Mechanical Restraint for SIB and Crisis Intervention Restraint. Two individuals (in April and May 2012) had Protective Mechanical restraints and in the previous version of the restraint policy these restraints were subject to the criteria of C.7. With the implementation of the Use of Restraint Policy on 6/1/12 only Crisis Intervention Restraints were applicable to the C.7 criteria. Beginning in June 2012 these two individuals with Protective Mechanical Restraint no longer met the criteria for C.7 and were not audited for this element in restraint audit samples. One individual with Crisis Intervention Restraint met the criteria for C.7 in June 2012. This individual's ISP addendum was reviewed during the restraint audit and the compliance results for C.7.a were 100%. During the months of April, May, and June 2012 restraint audit compliance results for Provision C.7.a received 100% compliance. There were no Crisis Intervention Restraints that met the more than three restraints in a rolling 30 days period in July 2012.<br>2. The review of samples of the ISP Addendums indicates that there were documentation issues noted for one individual receiving protective mechanical restraint related to their ISP Addendum meeting minutes (April and May 2012). The other two individuals meeting the criteria of C.7.a, review of adaptive skills and biological, medical, and psychosocial factors, addendum minutes included this information. Since June 2012, one individual met the C.7 criteria and his resulting meeting minutes have been 100% compliant with inclusion of C.7.a elements.<br><br>Based on the findings from this self-assessment, this provision is not in substantial compliance because documentation issues were noted with one individual's protective mechanical restraint ISP Addendum meeting minutes. For the remaining two individuals meeting these criteria, elements of C.7.a. received compliance ratings of 100%. Since June 2012, only one individual met the C.7 criteria. His resulting addendum meeting | Noncompliance |

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| | | minutes have been compliant with C.7.a at 100% compliance.<br><br>Monitoring Team Findings:<br>For none of the instances reviewed for this individual (0%), the IDT adequately reviewed the individual's adaptive skills. The following is an example of when the team failed to do this adequately:<br>• For the two of three instances in which the IDT reviewed restraint, the review of adaptive behavior was inadequate. On 4/26/2012, no review of adaptive behavior was presented. The review conducted on 5/10/2012 presented information on adaptive behavior, but this information lacked detail and did not contribute to an understanding of the use of restraint.<br><br>For the two of three instances (67%) reviewed by the individual's IDT, the team reviewed biological, medical and psychosocial factors. The following is an example of when this review was done appropriately:<br>• On 4/26/2012, the IDT conducted a thorough review of biological, medical, and psychosocial factors. The review conducted on 5/10/2012 was briefer, but summarized the findings from the 4/26/2012 review and indicated that previous findings remained valid. | |
| | (b) review possibly contributing environmental conditions; | Facility Self-Assessment:<br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Review of monthly restraint audit compliance results for the months of April 2012 through July 2012.<br>2. Review of ISP addendums for inclusion of the review of possible contributing environmental conditions.<br><br>From its self-assessment the Facility determined that:<br>1. Monthly restraint audit compliance results for the months of April through July 2012, for individual's meeting the more than three restraints in a rolling 30 day period, were at 100% compliance for Provision C.7.b. The number of individuals restraints applicable to this provision are the same as those noted in C.7.a. There were no individuals meeting the criteria of more than 3 restraints in a rolling 30 days in July 2012.<br>2. Review of samples of ISP Addendums indicates review of possible contributing environmental conditions was included in the discussion and meeting minutes for two of the three individuals meeting these criteria. Documentation issues were noted with one individual's protective mechanical restraint ISP Addendum meeting minutes. For the remaining two individuals meeting this criteria, the | Noncompliance |

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| | | contributing environmental conditions, were reviewed. Since June 2012, one individual met the C.7 criteria and the resulting addendum meeting minutes were compliant with C.7.b at 100%.<br><br>Based on the findings from this self-assessment, this provision is not in substantial compliance because there were documentation issues noted for one individual's protective mechanical restraint ISP Addendum meeting minutes. Since June 2012, one individual met the C.7 criteria and his resulting meeting minutes have been compliant with C.7.b at 100%.<br><br><u>Monitoring Team Findings:</u><br>For the two of three instances (67%) reviewed by the individual's IDT, the team reviewed the possibly contributing environmental conditions. The following is an example of when this review was done appropriately:<br>• On 4/26/2012 and 5/10/2012, documentation reflected that the IDT discussed environmental factors relating to behavior displays and the use of restraint. This discussion was integrated into the review of the functional assessment of self-injurious behavior. | |
| | (c) review or perform structural assessments of the behavior provoking restraints; | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Review of monthly restraint audit compliance results for the months of April 2012 through July 2012.<br>2. Review of PSP addendums for inclusion of the review of the current structural assessment of the behavior provoking restraint or the recommendation to perform a structural assessment.<br><br>From its self-assessment the Facility determined that:<br>1. Monthly restraint audit compliance results for the months of April through July 2012, for individual's meeting the more than three restraints in a rolling 30 day period, were at 100% compliance for Provision C.7.c. There were no individuals meeting the criteria of more than 3 restraints in a rolling 30 days in July 2012.<br>2. Review of ISP Addendums indicates review of the findings of the individual's current structural assessment of the behavior provoking restraints was included in the discussion and meeting minutes for two of the three individuals meeting these criteria. Documentation issues were noted with one individual's protective mechanical restraint ISP Addendum meeting minutes. For the remaining two individuals meeting these criteria, the findings were used to develop Positive Behavior Support Plans for these individuals. | Noncompliance |

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| | | Based on the findings from this self-assessment, this provision is not in substantial compliance because there were documentation issues noted for one individual's protective mechanical restraint ISP Addendum meeting minutes. Since June 2012, one individual met the C.7 criteria and his resulting meeting minutes have been compliant with C.7.c at 100%.<br><br>Monitoring Team Findings:<br>For the two of three instances (67%) reviewed by the individual's IDT, the team reviewed structural assessments of the behavior provoking restraints. The following is an example of when this review was done appropriately:<br>• On 4/26/2012, the IDT conducted a thorough review of the behavior assessment results and PBSP. This review was replicated on 5/10/2012, at which time the IDT discussed the role of antecedents to the self-injury. | |
| | (d) review or perform functional assessments of the behavior provoking restraints; | Facility Self-Assessment:<br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Review of monthly restraint audit compliance results for the months of April 2012 through July 2012.<br>2. Review of ISP addendums for inclusion of the review of the current functional assessment of the behavior provoking restraint or the recommendation to perform a functional assessment.<br><br>From its self-assessment the Facility determined that:<br>1. Monthly restraint audit compliance results for the months of April through July 2012, for individual's meeting the more than three restraints in a rolling 30 day period, were at 100% compliance for Provision C.7.d. There were no individuals meeting the criteria of more than 3 restraints in a rolling 30 days in July 2012.<br>2. Review of ISP Addendums indicates review of the findings of the individual's current functional assessment of the behavior provoking restraints was included in the discussion and meeting minutes for two of the three individuals meeting these criteria. Documentation issues were noted for one individual's protective mechanical restraint ISP Addendum meeting minutes. For the other two individuals who met the criteria of C.7, the findings of the functional assessments were used to develop Positive Behavior Support Plans for these individuals. Since June 2012, one individual met the C.7 criteria and his resulting meeting minutes have been compliant with C.7.d.<br><br>Based on the findings from this self-assessment, this provision is not in substantial compliance because there were documentation issues noted for one individual's protective mechanical restraint ISP Addendum meeting minutes. Since June 2012, one | Noncompliance |

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| | | individual met the C.7 criteria and his resulting meeting minutes have been compliant with C.7.d at 100%.<br><br>Monitoring Team Findings:<br>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. | |
| | (e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP; | Facility Self-Assessment:<br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Review of monthly restraint audit compliance results for the months of April 2012 through July 2012.<br>2. Review of ISP addendums for the inclusion of review and discussion of the current Positive Behavior Support Plan (to include each element listed in Provision C.7.e) and/or the recommendation to develop a Positive Behavior Support Plan is one does not exist.<br><br>From its self-assessment the Facility determined that:<br>1. Monthly restraint audit compliance results for the months of April through July 2012 indicate consistent high levels of compliance for C.7.e. (development/implement of a Positive Behavior Support Plan based on the individual's strengths specifying defined targeted behavior leading to restraint, alternative/adaptive behaviors to be taught to replace targeted behavior initiating the use of restraint along with the implementation of other programs or supports that aide in the reduction of the use of such restraint; type of restraint authorized, restraint's maximum duration, designated approved restraint situation and criteria for terminating restraint). Compliance results, for the months in which restraints meeting the C.7 criteria, were at 100% for C.7.e.<br>2. Review of ISP Addendums for more than three restraints in a rolling 30 day period reflect the inclusion of elements listed in C.7.e. in addendum minutes with the exception of one individual who receives protective mechanical restraint. Documentation issues were noted for this one individual's ISP Addendum meeting minutes. Since June 2012, one individual met the C.7 criteria and the resulting meeting minutes were compliant with C.7.e at 100%.<br><br>Based on the findings from this self-assessment, this provision is not in substantial compliance. Restraint audit results of restraints meeting the criteria of C.7 were at 100% each month applicable restraints were audited. However, ISP Addendums, when reviewed, included documentation issues for one of the individuals with protective mechanical restraint. Since June 2012, one individual met the C.7 criteria and his | Noncompliance |

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| | | resulting meeting minutes were compliant with C.7.e at 100%.<br><br><u>Monitoring Team Findings:</u><br>For two of three instances of restraint (67%) there was documentation of a review by the individual's IDT that included the individual's PBSP. The PBSP was originally developed in February 2012 and was based upon a functional assessment completed at the same time. Minor revisions were made to the PBSP in May 2012 and August 2012. Documentation by the Positive Behavior Support Committee and Human Rights Committee reflected that these revisions involved issues other than the use of or need for restraint.<br><br>The PBSP developed for Individual #537 included strategies that emphasized antecedent- and setting-based interventions, as well as procedures for encouraging appropriate communication and participation in activities. In addition, the following was found regarding the individual's PBSP:<br>• One (100%) was based on the individual's strengths;<br>• One (100%) specified the objectively defined behavior to be treated that led to the use of the restraint;<br>• One (100%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint; and<br>• One (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. | |
| | (f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Review of monthly restraint audit compliance results for the months of April 2012 through July 2012.<br>2. Review of PSP addendums for inclusion of discussion of treatment integrity of the current Positive Behavior Support Plan.<br><br>From its self-assessment the Facility determined that:<br>1. Monthly restraint audit results for the months of April through June 2012 indicate compliance ratings of 100% for C.7.f. There were no restraints meeting the C.7 criteria for the month of July 2012.<br>2. Review of ISP addendums for inclusion of treatment integrity revealed that this information is not consistently documented in addendum meeting minutes. It is likely treatment integrity is being reviewed by Behavior Services staff but is located in another document such as a monthly progress note. | Noncompliance |

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| | | Based on the findings from this self-assessment, this provision is not in substantial compliance because compliance results from monthly audits are not an accurate reflection of inclusion of treatment integrity in the ISP Addendum.<br><br>Monitoring Team Findings:<br>The individual's behavioral data and/or treatment integrity checks did not document that the PBSP was implemented with a high level of treatment integrity. At the time of the current site visit, information provided by the Facility did not indicate that treatment integrity checks were consistently or routinely conducted for the PBSP in question. | |
| | (g) as necessary, assess and revise the PBSP. | Facility Self-Assessment: The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Review of monthly restraint audit compliance results for the months of April 2012 through July 2012.<br>2. Review of ISP addendums for inclusion of recommendations to assess or revise the Positive Behavior Support Plan, and if recommended the completion of assessment or revision.<br><br>From its self-assessment the Facility determined that:<br>1. Monthly restraint audit results for the months of April through June 2012 indicate compliance ratings of 100% for C.7.g. There were no restraints meeting the C.7 criteria for the month of July 2012.<br>2. Review of ISP addenda for inclusion of recommendations to assess/revise the Positive Behavior Support Plan indicated that when recommended, this information is included in the addendum minutes for two out of the three individuals' meeting minutes sampled. Documentation issues were noted in one of the protective mechanical restraint meeting minutes for one individual. In not all cases is it recommended to assess/revise the plan, it was only recommended when appropriate to do so. Since June 2012, one individual met the C.7 criteria and his resulting meeting minutes have been compliant with C.7.g at 100%.<br><br>Based on the findings from this self-assessment, this provision is not in substantial compliance. Restraint audit results of restraints meeting the criteria of C.7 were at 100% each month applicable restraints were audited. However, in reviewing ISP Addenda documentation problems were noted for one of the individuals with protective restraint. Since June 2012, one individual met the C.7 criteria and his resulting meeting minutes have been compliant with C.7.g.<br><br>Monitoring Team Findings:<br>For the two of three instances (67%) reviewed by the individual's IDT, there was documentation that the individual's PBSP had been revised as appropriate. The following | Noncompliance |

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| | | are examples of individuals for whom this was done appropriately:<br>• For Individual #537, the PBSP data reflected that the individual's PBSP had been revised in April 2012 due to increases in behaviors targeted for reduction. | |
| 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:<br>1. Review of monthly restraint audit compliance results for the months of April 2012 through July 2012.<br>2. Review of the facility Quarterly Quality Assurance/Quality Improvement (QA/QI) data for restraint.<br>3. Review of IRT and IMRT meeting minutes section for the review of restraint within three business days from start of restraint (other than medical) from April 2012 to August 2012.<br><br>From its self-assessment the Facility determined that:<br>1. Monthly restraint audit compliance results for the months of April through July 2012 indicate 100% compliance for review of restraints, other than medical restraints, within three business days. In addition, the clinical discussion of crisis intervention restraints occurs within three business days and is documented in the IRT meeting minutes. The clinical discussion includes the review of antecedents, reason for the restraint, any contributing environmental issues and any recommendations from the restraint review. Behavior Services staff continue to conduct restraint de-briefings for crisis intervention restraints following the episode of restraint, and this information is reviewed in the IRT as well.<br>2. Quarterly QA/QI data confirms the findings in monthly restraint audit compliance results.<br>3. Review of IRT and IMRT meetings minutes indicate that restraints, other than medical, are being reviewed within three business days of the start of the restraint.<br><br>Based on the findings from this self-assessment, this provision is in substantial compliance because reviews of restraint use and the circumstance under which the restraint was used are occurring within three days and are substantive reviews. The Behavior Services staff also completes a restraint de-briefing for each episode of crisis intervention restraint and the information from this de-briefing is included in the clinical review and discussion at the IRT. Restraint audit compliance results remain at 100% for the months of April through July 2012. | Substantial Compliance |

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| | | Monitoring Team Findings:<br>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 17 crisis intervention restraints involving eight different people. The sample consisted of four restraints involving four different Individuals.<br><br>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.<br><br>The Monitoring Team reviewed documentation related to four 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, ISP addendums resulting from the review process, and any related documents. IMRT meeting minutes included 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 frequency of crisis intervention restraint use at the Facility continues on a downward trend. There were no crisis intervention restraints during the week of the review so the Monitoring Team could not observe a restraint review at either a Unit morning meeting or an IMRT meeting. Written documentation supported the conclusion that reviews occurred timely and, as reported in the last review, were substantive in nature.<br><br>Sample C.1 documentation reviewed by the Monitoring Team showed that:<br>▪ In four (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.<br>▪ In four (100%), the review by the IMRT occurred within three business days of the restraint episode and this review was documented in IMRT minutes.<br>▪ In four (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 | |

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| | | documented on the Behavioral Services Debriefing report. When appropriate this review included review of video surveillance recordings.<br>▪ In four (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.<br>▪ In four (100%), the review conducted by the Unit IDT and the IMRT resulted in an additional referral to the IDT for review and consideration of possible changes in active treatment plans, positive behavior plans, and other aspects of the ISP that effect the behavior of the individual; and<br>▪ Of the four referred to the team, four (100%) resulted in changes made to the individuals' ISPs and these changes appeared appropriate to the circumstances. For example, Individual #667's IDT met after a restraint on 5/12/12 and initiated changes to the treatment, prevention, and management sections of the PBSP.<br><br>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 sometimes 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.<br><br>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. 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. | |

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| | | This Provision is in substantial compliance. | |

**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, C.3, C.4, and C.5).
2. Monitoring of implementation of medical restraints needs to be more rigorous (Provisions C.1, C.4, C.5, and C.6).
3. Additional training of staff on medical restraint procedures and documentation is needed (Provision C.1, C.4, C.5, and C.6).
4. Competency checks of staff knowledge to ensure training received is retained should be done more regularly. (Provision C.4)
5. Nursing staff should receive additional training in monitoring requirements associated with the use of restraints.
6. Nursing staff should be held to accountability standards for proper restraint monitoring.
7. 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 more than three restraints in a rolling 30 day period. (Provision C.7)
8. Especially for individuals experiencing restraint, treatment integrity checks should be done to ensure PBSPs are implemented accurately (Provision C.7)

The following are offered as additional suggestions to the facility:

1. Continue the practice of immediate retraining of staff as auditors/monitors discover issues.
2. 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 | |
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| 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:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment 9/24/12<br>2. DSSLC Action Plan 9/24/12<br>3. Settlement Agreement (SA) Section D Presentation Book (undated)<br>4. DADS Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation 5/11/11<br>5. DADS Policy 02.3 Incident Management 1/31/11<br>6. DSSLC Policy CMGMT-01A Protection from Harm – Abuse, Neglect, and Exploitation 7/30/10<br>7. 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<br>8. Minutes of DSSLC's quarterly meeting with Department of Family and Protective Services (DFPS) 8/2 and 9/5/12<br>9. Training Curriculum for Course ABU0100 Abuse and Neglect 4/25/12<br>10. Sample of Employee Training Records – Sample C.2<br>11. DADS Report MHMR0102 Percent of All Employees Completing Courses of Training Program 9/1/12<br>12. Sample of Acknowledgment of Responsibility for Reporting Abuse, Neglect, and Exploitation employee forms.<br>13. DSSLC Annual Employee Registry Check and Fingerprint Criminal History Check dated 10/12/12<br>14. DSSLC report on volunteer background checks 9/13/12<br>15. "You Have the Right" poster 7/17/09<br>16. "Report Abuse or Neglect" poster 4/05<br>17. "Prevent Abuse & Neglect Poster" (undated)<br>18. Current mailer to LARs regarding abuse, neglect, and exploitation<br>19. Incident Management Review Team Meeting minutes for 6/22, 6/29, 7/6, 7/13, 7/20, 7/27, 8/3, 8/10, 8/17, 8/24, 8/31, and 9/7/12<br>20. Allegation, Injury, and UIR Trend Report 9/12<br>21. Individual Training Records for Facility and Department of Family and Protective Services (DFPS) Investigators<br>22. DFPS case log 4/1/12 to 10/8/12<br>23. OIG case log 4/1/12 to 10/8/12<br>24. Log of employees reassigned from client contact 4/1/12 to 9/13/12<br>25. Serious Injury log 4/1/12 to 10/8/12<br>26. Witnessed Injury log 4/1/12 to 10/8/12<br>27. List of the most frequently injured Individuals 9/2/11 to 2/28/12<br>28. Discovered Injury log 4/1/12 to 10/8/12<br>29. Serious Incidents log 4/1/12 to 10/8/12 |

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| | 30. Peer caused injury log 4/1/12 to 10/8/12<br>31. Discovered Injury Investigation for Individuals #85, #168, #247, #289, #367, and #697<br>32. UIRs and other documentation related to DSSLC serious injury investigations: Individual #650 (7/24), Individual #435 (7/27), Individual #186 (6/21), Individual #737 (7/15), and Individual #350 (8/22)<br>33. Other UIRs: 184, 194, 247, and 250<br>34. DFPS Investigation files for compliance review sample: 42412183, 41862392, 42212298, 4273414, 42348810, 42360056, 42381308, 42386726, 42396791, 42412423, 42428551, 42429177, 42439122, 41767596, 42369561, and 42409428.<br>35. Additional DFPS Investigation files: 41945796 and 42212298<br>36. DFPS cases referred back to the Facility: 41838836, 42273414, 41755953, 41917122, 42340685, 42095252, 41958454, 42350978, 42354038, and 42342325<br>37. OIG investigations 09005-12, 09019-12, and 09263-12<br>38. List of employees who failed to report or were late in reporting<br>39. Under Reporting Audit reports July, 2012<br>40. Rights Poster Audit reports July, 2012<br>41. Self-Advocacy meeting minutes: 4/27, 5/30, 6/22, 7/19, and 8/31/12<br>42. QA/QI committee meeting minutes: April, 2012 through September, 2012<br>**People Interviewed:**<br>1. Deb Salsman, Director of Incident Management<br>2. Jeron Dotson, Incident Management Coordinator<br>3. Dora Tillis, Assistant Director of Programs<br>4. Nora Brookins, Program Auditor<br>5. Ten Direct Care Professionals (DCP's) at Timberhill Unit<br>**Meetings Attended/Observations:**<br>1. Incident Management Team (IMRT) 10/11/12<br>2. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 10/9/12<br>3. Individual Support Plan annual planning meeting for Individual #250 |
| | **Facility Self-Assessment:**<br>There are 22 Provisions or components of Provisions in Section D of the SA. The DSSLC self-assessment reported substantial compliance with 16. The Monitoring Team determined substantial compliance with 15. The Monitoring Team did not agree with the Facility self-assessment as to the compliance rating for Provision D.4 (tracking and trending data). The Facility self-assessment reported substantial compliance with three of the five complete provisions in this section. The Monitoring Team validated compliance with only two. These were Provision D.1, which addressed required policy components, and Provision D.5, which addressed required background checks of employees and volunteers. As noted in the last report, 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 Monitoring Team noted improvement in this regard but as reported in the Facility self-assessment more improvement is needed.<br><br>The self-assessment conducted by the Facility sometimes lacked detail and comprehensiveness. For |

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| | example, some sections did not address each element of each Provision or component of a Provision. For example, in assessing the training requirements associated with investigators the Facility reviewed the prerequisite requirements for Facility investigators but not DFPS investigators.<br><br>The Facility's self-assessment process and methodology was not always clearly presented. For example, the self-assessment for Provision D.2.a. reported that the Facility had "reviewed investigations to see if staff reported ANE and serious injuries to the director according to policy", and, "reviewed 122 investigations." In reporting the results the Facility stated "reviewed 10 investigations (random sample)…showed they had been reported according to policy", and, "112 of 122 (92%) of the investigations showed the Director was notified in a timely fashion." If the Facility in doing its self-assessment choose to conduct a 100% review (which was presumably what the review of 122 investigations represented although this was not specifically stated) it would not appear to be necessary to also conduct a small random sample. Alternatively, if the Facility choose to use a sampling methodology to test compliance with this provision it would not appear necessary to conduct a 100% review. It could be that the 100% review of investigation documentation is a customary management and supervisory oversight responsibility in which case activity directed at self-assessment should probably test a sample to ensure the accuracy of management and supervisory oversight. It would be useful for the Facility to be clear about specifically how information was gathered.<br><br>In its last report the Monitoring Team noted that future self-assessments should be more descriptive. This is still needed. For example, for Provision D.2.f the self-assessment reported "reviewed audits" without specifying how many, whether what was reviewed was 100% of audits or a sample, and (if a sample) the sample size. Similarly, in provisions that assessed various aspects of investigations the self-assessment did not describe what type of incidents were the subject of the investigations (e.g., DFPS investigations and if so what type, OIG investigations, serious injury investigations, discovered injury investigations, serious incident investigations, or others), how the cases were reviewed, whether or not the review activity was 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.<br><br>The Facility's Action Plan that accompanied the self-assessment did not contain any action steps that had been initiated since the last review which would address provisions in Section D that are still not in substantial compliance. Despite this there was some evidence in the self-assessment that action steps had been taken but not noted in the Action Plan document. For example, the self-assessment reported that an audit form had been revised to include reporting<br>all significant non-serious injuries. This was not noted in the Action Plan.<br><br>The Facility self-assessed six provisions as not in compliance yet did not initiate any action steps in its Action Plan that would address these six provisions. This is of concern to the Monitoring Team. Additional action steps will need to be developed to address issues identified by the Monitoring Team that are not sufficiently addressed in the current Facility Action Plan. |

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| | **Summary of Monitor's Assessment:**<br>The Facility was found to be in substantial compliance with a number of provisions and components of provision in this section of the Settlement Agreement and does many things well. This is an increase in compliance compared to what was noted in the last report. Two complete Provisions were found in substantial compliance. These were Provision D.1, which addressed required policy components, and Provision D.5, which addressed required background checks of employees and volunteers. The work effort in most provisions that have been previously determined to be in compliance remained in place.<br><br>The Facility process for review of DFPS investigation reports had substantially improved compared to what was observed at the last review.<br><br>The Facility improved its practices in reviewing DFPS reports and following up with DFPS on issues, including when necessary conducting follow-up investigations after assessing the completeness and accuracy of a DFPS report. The Facility is to be commended for its improvement in reviewing DFPS investigations.<br><br>The Facility was doing a good job of completing follow-up investigations when they receive an administrative referral back from DFPS.<br><br>Facility data reported a significant increase (quarter to quarter) in the number of DFPS allegations (58 to 64 to 83) but the trend line for confirmed cases was showing fewer confirmed cases.<br><br>Late reporting of serious incidents was still a problem.<br><br>The thoroughness and completeness of DFPS investigations was still a problem. In one case witnesses weren't interviewed until the Facility brought this to DFPS's attention and they came back out. Another case was mishandled because the alleged incident was reported to have happened at a fast food restaurant, the investigator did not validate the location of the restaurant, and subsequently questioned staff at the wrong restaurant.<br><br>Investigations of serious discovered injuries, while improved, needed further improvement.<br><br>The Facility determines a cause for every discovered injury often based on little or no evidence. Typically a plausible probable cause is determined based on various opinions expressed by staff, usually related to the individual's general demeanor and behavior, but not supported with any specific evidence related to the specific injury.<br><br>The Facility demonstrated 100% compliance with the staff training requirements associated with abuse, neglect, and exploitation, and unusual incidents. Staff knowledge, when queried by the Monitoring Team, was variable.<br><br>Reporting procedures were prominently displayed throughout the Facility and are printed on the back side |

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| | of employee identification badges.<br><br>In every instance where an alleged perpetrator (AP) was known, the AP was immediately placed in no direct contact status.<br><br>In all but one allegation of physical abuse in the sample drawn by the Monitoring Team, law enforcement notification occurred.<br><br>Compliance with required background checks was confirmed.<br><br>Facility investigation reports of serious discovered injuries were not always sufficient in scope and depth to provide a clear basis for investigation conclusions.<br><br>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.) and other variables, including data that can tell the Facility, for example, if the frequency of confirmed and/or inconclusive findings is increasing or decreasing and at what locations and work shift. Trend data should be presented in a manner that lends itself to useful analysis, discussion, and decision-making. |

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| D1 | Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals. | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Reviewed local policies that address Abuse, Neglect and Exploitation (ANE) to determine if zero tolerance commitment and staff reporting responsibilities are included.<br>2. Reviewed Tracking of reporting requirements from 4/1/12 to 9/5/12<br>3. Reviewed actions taken following confirmation of ANE.<br><br>From its self-assessment the Facility determined that:<br>1. The local policy "Protection from Harm-Abuse, Neglect and Exploitation" clearly includes the facility's commitment to zero tolerance of ANE and staff responsibility for reporting ANE<br>2. 110 of 120 investigations (92%) were reported on time .Those not reported on time resulted in retraining or disciplinary action being taken with staff.<br>3. A review of all ANE investigations with an outcome of confirmed from 04/01/2012 to 09/12/2012 reflected that in 11 out of 11 investigations (100%) of the employees with an ANE confirmation were terminated.<br><br>Based on the findings from this self-assessment, this provision remains in substantial | Substantial Compliance |

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| | | compliance because the local policies address the commitment of zero tolerance of ANE and staff responsibility to report ANE.<br><br><u>Monitoring Team Findings:</u><br>The Facility's policies and procedures did:<br>• Include a commitment that abuse and neglect of individuals will not be tolerated,<br>• Require that staff report abuse and/or neglect of individuals.<br><br>The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals.<br><br>The Facility policy stated that all employees who suspect or have knowledge of, or who are involved in an allegation of abuse, neglect, or exploitation, must report allegations immediately (within one hour) to DFPS and to the director or designee.<br><br>In practice, the Facility appeared committed to ensure that abuse and neglect of individuals was not tolerated, and encouraged staff to report abuse and/or neglect, as illustrated by examples provided throughout this Section D of the report.<br><br>The criterion for substantial compliance for this provision is the presence and dissemination of appropriate state and facility policies. Implementation of these policies on a day to day basis is monitored throughout the remaining items of section D of this report.<br><br>This Provision was in substantial compliance.. | |
| D2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require: | | |
| | (a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Reviewed investigations to see if staff reported ANE and serious injuries to the director or designee according to policy. | Noncompliance |

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| | deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting. | 2. Reviewed Campus Administrator monitoring forms to see if staff reported that they knew how to report and when to report ANE.<br>3. Reviewed 122 investigations to see if Center Director or Designee was notified in a timely fashion.<br><br>From its self-assessment the Facility determined that:<br>1. Reviewed 10 investigations (random sample) from 5/1/12 to 9/1/12, investigations from the sample showed that they had been reported to the director according to policy.<br>2. Review indicated staff knowledgeable of how and when to report ANE.<br>3. 112 of 122 (92%) of the investigations showed that the Center Director/Designee was notified in a timely fashion.<br><br>Based on the findings from the self-assessment, this provision is not in substantial compliance because there were 10 instances of late reporting although 92% of all incidents were reported according to policy.<br><br><u>Monitoring Team Findings:</u><br>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.<br><br>From a response to a document request asking for the six month period from 4/1/12 through 9/30/12 - total number of abuse allegations and disposition/status, the following data were provided by the Facility:<br><br>Total Number of Abuse Allegations 105<br>Confirmed 8<br>Unconfirmed 66<br>Inconclusive 7<br>Unfounded 7<br>Administrative Referral 5<br>Disposition Pending 7<br>Information & Referral 3<br><br>Total Number of Neglect Allegations 24<br>Confirmed 5<br>Unconfirmed 8 | |

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| | | Inconclusive 1<br>Administrative Referral 10<br>Disposition Pending 0<br><br>Total Number of Exploitation Allegations 3<br><br>Administrative Referrals 3<br><br>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.<br><br>Two samples of investigations were selected for review. These included:<br>• Sample D.1 of 16 DFPS investigations of abuse, neglect, and/or exploitation between 4/1/12 and 9/17/12. This sample included the following DFPS investigation reports: 42412183, 41862392, 42212298, 4273414, 42348810, 42360056, 42381308, 42386726, 42396791, 42412423, 42428551, 42429177, 42439122, 41767596, 42369561, and 42409428. This represented a 20% sample of cases. The sample was selected by working back from the most recent investigation and selecting the only Class I allegation, two allegations made by an Individual living at the Facility, one inconclusive allegation of physical abuse, one inconclusive allegation of verbal abuse, three Class II cases of confirmed abuse, three Class II cases of unconfirmed abuse, three Class II allegations administratively referred back to the Facility, and two Class II cases which were determined to be unfounded.<br><br>Because three of the cases in the sample were administrative referrals, some analysis in this report will refer to the 13 allegations subject to a complete investigation.<br>• Sample D.2 of five facility investigations of serious injuries. DSSLC provided a report entitled Serious Injury Report, which listed serious injuries to individuals from 4/1/12 to 9/14/12. From this report the Monitoring Team was able to determine the DSSLC had 26 serious injuries during this time period. From these 26, five (20%) were selected for Sample D.2 to assess the adequacy of the facility investigation process. All five were discovered injuries.<br><br>In reviewing Sample D.1 (DFPS case reports), six of the 13 investigations noted a date and/or time the incident occurred (the other seven noted "unknown") and a date and time the incident was reported to DFPS. None (0%) of these six incidents were reported to DFPS within one hour of discovery as required by policy. For example, case 42360056 | |

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| | | reported the date of the alleged incident as 7/1/12 (time unknown). DFPS did not receive the report of the incident until 7/2/12. Case 42386726 reported the date of the alleged incident as 7/20/12 and the time as 8:30am. DFPS did not receive the report of the incident until 7/22/12. Other incidents that were reported late were 42396791, 42412183, 42428551, and 42369561. The Monitoring Team findings related to late reporting confirm the Facility's self-assessment that it has a problem with late reporting.<br><br>In reviewing Sample D.2 (serious injuries), three of five (60%) were not reported immediately (within one hour) to the Facility Director/designee. Those that were not reported within one hour were UIRs 236, 241, and 261. It appeared in one case that the injury was not immediately reported because a nurse was waiting for a physician to "officially" classify the injury as a serious injury, even though this injury was a fracture to the left fibula and left tibia and the injury report included a graphic description of the visible extent of the injury. It was obvious this would be classified as a serious injury. Facility staff should report injuries believed to be serious immediately to the Facility Director/designee even if a physician had not as yet officially classified the injury as such. This is necessary to ensure the Facility Director can validate that all appropriate client protection measures have, or are in the process of, taken place.<br><br>Samples D.1 and D.2 showed nine instances of late reporting. In a pre-visit document request, the Monitoring Team asked the Facility to provide a list of incidents that were reported late. Eight incidents were identified on this list, which included notations on follow-up action taken. Only two of the nine incidents identified by the Monitoring Team (22%) were on the list provided by the Facility; the list did not include the other seven incidents of late reporting found in the samples. The Monitoring Team is concerned that the Facility is not critically scrutinizing the circumstances associated with an incident, and when it was reported, to ensure needed corrective action steps are identified and taken. The problem of late reporting appears to be systemic which would suggest a need for a more aggressive and comprehensive corrective action plan. It appears that Facility response to date has been to take action with specific offending employees. While this is necessary it does not appear to be sufficient in correcting this important compliance requirement of the SA.<br><br>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. If abuse/neglect cannot be ruled out then most are to be reported as an allegation to DFPS for investigation. There may be circumstances where neglect was discovered in these Facility investigations of non-serious discovered injuries but which do not meet the State (DADS and DFPS) definition of neglect, thereby not warranting referral to DFPS. The Facility had experienced 472 non-serious | |

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| | | discovered injuries between 4/1/12 and 10/8/12.<br><br>The Facility policy that has been in place for years requires that non-serious discovered injuries receive a preliminary review (i.e. investigation) at the residential unit level and this review be documented on the Discovered Injury Investigation Worksheet. The Monitoring Team selected a sample of six non-serious injuries and asked the Facility to prepare a file for each with evidence to support its investigation, and to validate that a determination had been made that ruled out abuse or neglect as a cause or contributing factor of the injury. The Facility was unable to produce a Discovered Injury Investigation Worksheet for four of the six (67%) sampled injuries. In reviewing the two Discovered Injury Investigation Worksheets that were produced one was devoid of useful information and one was marginally acceptable. Five of six (83%) non-serious discovered injuries in the sample were not sufficiently investigated to rule out abuse or neglect as a cause or contributing factor of the injury. The Facility reported it had initiated a new process for the review of discovered injuries in May. Four of the six injuries reviewed occurred after May. It appears the Facility did not have any administrative or management controls to ensure the policy-required process for the investigation of discovered non-serious injuries was carried out.<br><br>When the Monitoring Team reviewed the above information with the Facility they noted that a new process was initiated for the review of non-serious discovered injuries. The scope of this new process was not apparent as no revisions occurred to Facility policy and no draft revisions were presented to the Monitoring Team. Information in this regard presented the Action Plan accompanying the Facility self-assessment was vague, stating only "revise process for discovered injuries" with a start date of 11/1/11 and a completion date of 1/31/13. The Facility voluntarily provided the Monitoring Team with recent investigations of non-serious injuries which were purported to demonstrate improvement. These investigations were done by campus administrators who are trained investigators. It was not clear if all non-serious discovered injuries are now investigated by trained investigators (not likely because of the volume), or some, and if some the criteria used to determine that an injury should be investigated by a trained investigator. Those recent investigations submitted to the Monitoring Team included an injury to a toenail, a breast bruise, a small cut to the palm of a hand, a skin tear on a shin, and a chest bruise. These investigations were much better than those reviewed from the sample selected by the Monitoring Team. This would be expected since they were done by trained investigators. Nevertheless, they were not without problems. For example, an injury to Individual #441 on 9/21/12 was reported on the Discovered Injury Worksheet as an injury to the toe. The shift log submitted as part of the investigation also described a "scratch to the forehead with a small amount of bleeding" as part of the same entry describing the injury to the toe. It was not clear if this injury was also investigated. Presumably they should have been investigated together as both injuries could have | |

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| | | resulted from the same event.<br><br>The Facility reported to the Monitoring Team that it had taken recent steps to improve the investigation on non-serious discovered injuries, including administrative and managerial control mechanisms. The Monitoring Team looks forward to assessing these improvements at the next review.<br><br>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><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Reviewed AP reassignment log to determine that all alleged perpetrators were not in direct contact with individuals until the investigation was completed.<br>2. Reviewed 10 investigations (random sample) from 5/1/12 to 9/1/12, to see if reassignment/other protective actions occurred to protect individuals.<br>3. Reviewed Campus Coordinator's Sign In sheets to reassigned staff.<br><br>From its self-assessment the Facility determined that:<br>1. The reassignment log shows that a 100 % of all identified alleged perpetrators (APs) were removed from direct contact with individuals until the investigation was complete<br>2. Review of the sample of investigations indicated that in 100% the alleged perpetrator was not in direct contact with individuals until the investigation was completed.<br>3. Showed that all staff that were alleged perpetrators in ANE investigations were removed from direct contact with Individuals.<br><br>Based on the findings from this self-assessment, this provision is in substantial compliance because the log shows 100% for all alleged perpetrators being removed from direct contact with the individuals pending the completion of the investigation. The facility has had 10 instances of late reporting and APs were removed as soon as the Investigator on Duty (IOD) was notified.<br><br><u>Monitoring Team Findings:</u><br>Based on a review of the 13 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 4/1/12. The log included the applicable UIR number, the date of reassignment, the outcome of the investigation, and the date the | Substantial Compliance |

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| | | employee was returned to work if the employee was not discharged or had not resigned.<br><br>In its last report the Monitoring Team noted the relationship between late reporting (refer to Provision 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 identified by the Facility's internal review processes should include an assessment of this potential with respect to compliance with this Provision. The Facility did not provide any evidence that this occurred and needs to pay more attention to this in the future. This is especially important since, as reported in Provision D.2.a, several incidents were not reported until the day after they occurred.<br><br>Review of 13 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.<br><br>Based on a review of the 13 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.<br><br>The Monitoring Team has determined that the DSSLC was in substantial compliance with this component of the SA; however, continued compliance will be dependent upon the Facility's ability to determine that in instances of late reporting alleged perpetrators who (because of late reporting) were not immediately removed from contact with Individuals did not create risk of harm to any Individuals in their care until such time as they were placed in No Direct Contact status. | |
| | (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><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Reviewed the training compliance percentages report from Competency Training and Development (CTD).<br>2. Reviewed the ANE curriculum.<br><br>From its self-assessment the Facility determined that:<br>1. Training compliance for the following months for completion of ANE was<br>April – 99%<br>May - 99% | Substantial Compliance |

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| | | June – 99%<br>July – 100%<br>August – 99%<br>2. Reviewed the curriculum for ANE and determined the curriculum requires a demonstration of competency of recognizing ANE and reporting ANE in order to pass the training.<br><br>Based on the findings from this self-assessment, this provision remains in substantial compliance since training has remained at 99% or above and the curriculum is competency based.<br><br><u>Monitoring Team Findings:</u><br>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 the SA.<br><br>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:<br><br>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. It was reported that the content of training had been slightly modified in April with the primary change being the inclusion of more examples of situations that represent abuse or neglect. Additionally, it was reported that the test administered at the end of training was somewhat more competency based.<br><br>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.<br><br>All 25 staff had completed both training classes within the last 12 months.<br><br>There is some question as to whether or not staff retains knowledge learned in staff training classes. The Monitoring Team met with 10 Direct Care Professionals (DCPs) from an active residential area and asked four abuse related questions. Both morning and afternoon staff were represented. The first question was "from the training you've | |

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| | | received if you witness, or suspect, abuse what do you do?" One member of the Monitoring Team, one Facility QA staff, and one Facility administrator independently scored the responses. Therefore for each question there were 30 possible acceptable or unacceptable responses. Only 73% of the responses to this question were determined to be acceptable. The second question was "tell me what kinds of things, if you saw or heard of them, would constitute abuse?" Only 77% of the responses to this question were determined to be acceptable. The third question was "tell me what kinds of things, if you saw or heard of them, would constitute neglect?" Only 83% of the responses to this question were determined to be acceptable. The fourth question was "If retaliation happened, or was suspected, how do you think the facility administration would respond?" Only 93% of the responses to this question were determined to be acceptable. The Facility reported that Campus Administrators routinely "quiz" staff when making rounds and an example of the form used to document this activity was provided to the Monitoring Team. The Facility may wish to expand the frequency of these competency checks and be sure to hold staff to a high standard of demonstrated knowledge. Additionally, the Facility should compile data from this monitoring and subject it to thorough analysis to determine if additional action steps are warranted. Because of the issues with late reporting noted in Provision D.2.a this is an especially important topic.<br><br>The Monitoring Team had previously determined this Provision was in substantial compliance and finds compliance in this review, however; to maintain compliance the Monitoring Team expects to see improved staff knowledge demonstrated in future reviews. | |
| | (d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect. | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Reviewed Acknowledgement of Responsibility for Reporting Abuse, Neglect and Exploitation forms kept at the Competency Training and Development department.<br>2. Reviewed the distribution of the Acknowledgement of Responsibility for Reporting Abuse, Neglect and Exploitation forms for new signatures and spoke to the person who tracks them to completion.<br>3. Reviewed investigations to determine if anyone failed to report ANE<br>From its self-assessment the Facility determined that:<br>1. Reviewed 10 forms (random sample) from 4/1/12 to 8/1/12, ten of 10 (100%) were signed and acknowledged by staff.<br>2. This review revealed all were completed in 2011and new forms were distributed for signatures due 9/30/12.<br>3. Review indicated that there has been one instance where staff failed to report ANE and this staff no longer works here. | Substantial Compliance |

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| | | Based on the findings from this self-assessment, this provision remains in substantial compliance because 100% of the acknowledgement forms have been signed through 9/1/11.<br><br><u>Monitoring Team Findings:</u><br>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, all 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.<br><br>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.<br><br>The Facility, through its investigation review process, identified one instance where a mandatory reporter failed to report abuse (UIR 12-149). The Facility reported staff was retrained on abuse and neglect and reporting policy. Several instances of late reporting were noted in Provision D.2.a of this report. Several were not identified by the Facility through its management review process of incidents. Consequently, no personnel action was taken in those instances 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.<br><br>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. | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Reviewed a sample of the ISP packet sent to family members.<br>2. Reviewed investigations to see if individuals had reported ANE.<br>3. Reviewed investigations to see if family members have reported ANE.<br>4. Reviewed telephone interviews of a random sample of 20 family members per month to see if they were knowledgeable of ANE and how to report it.<br>From its self-assessment the Facility determined that:<br>1. The ISP Packet is still being sent and includes information regarding reporting ANE and retaliation.<br>2. Reviewed a random sample of 10 investigations from 5/1/12 to 9/5/12 and there was one instance where an individual reported ANE. | Substantial Compliance |

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| | | 3. Reviewed a random sample of 10 investigations from 5/1/12 to 9/5/12 there were no incidents where the Legally Authorized Representative (LAR) reported ANE. Although there were no instances of LAR reporting ANE in the random sample, the facility has had one incident of ANE reported by the LAR<br>4. All family members interviewed have indicated they knew how to report ANE.<br><br>Based on the findings from this self-assessment, this provision remains in substantial compliance because the center continues to distribute information on how to report and prevent and look for signs of ANE to family members/LAR, have reported ANE, express knowledge of how to report ANE as well as we have had individuals to report ANE.<br><br><u>Monitoring Team Findings:</u><br>Facility activity directed at compliance with this Provision included:<br>• Educational materials were provided to LARs and Individuals prior to each individual's ISP meeting.<br>• QDDPs individually reviewed the provisions of abuse and neglect reporting with Individuals prior to their ISP meeting.<br>• The topic of rights, including abuse and neglect were a regular part of each self-advocates meeting.<br><br>In reviewing Facility data the Monitoring Team identified four instances since the last review where allegations of abuse or neglect had been reported by Individuals living at the Facility or a family member. This suggests the educational efforts undertaken by the Facility are achieving their intended purpose.<br><br>Monitoring Team members attended the ISP annual planning meeting for Individual #250. At this meeting, information was provided regarding abuse/neglect reporting procedures.<br><br>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><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Reviewed Audits from Quality assurance auditor to determine whether the rights posters were posted in all living areas and program areas.<br><br>From its self-assessment the Facility determined that:<br>1. Reviewed audits from 4/1/12 to 9/5/12 and 10 of 10 (100%) reflect that the | Substantial Compliance |

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| | | Rights posters are posted and easily understood<br><br>Based on the findings from this self-assessment, this provision remains in substantial compliance because 100 % of the posters were posted in each living unit and day program according to policy.<br><br>Monitoring Team note: the Facility has determined that the rights poster is easily understood but does not describe how this conclusion was reached, for example periodically reviewing the poster content with several Individuals and staff.<br><br><u>Monitoring Team Findings:</u><br>The Facility was using the standard posters provided by DADS to inform Individuals, staff, and others of rights (including being free from abuse and neglect) and reporting procedures. Observations by the Monitoring Team of living units and day programs on campus showed that postings of individuals' rights were in areas to which individuals regularly had access.<br><br>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 and reported 100% compliance. Random building checks by the Monitoring Team also confirmed compliance.<br><br>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. | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Reviewed investigations to ensure that law enforcement had been notified of all investigations of ANE.<br><br>From its self-assessment the Facility determined that:<br>1. Reviewed 10 investigations (random sample) from 4/1/12 to 9/5/12, for 10 of 10 (100%) law enforcement were notified in all investigations reviewed.<br><br>Based on the findings from this self-assessment, this provision remains in substantial compliance because in all investigations where law enforcement needed to be notified, notification was made.<br><br>Monitoring Team note: the Facility reports all investigations where law enforcement needed to be notified, notification was made. No information is provided in the self- | Substantial Compliance |

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| | | assessment regarding criteria used to determine whether or not law enforcement notification is needed.<br><br>Monitoring Team Findings:<br>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.<br><br>In eight of nine (89%) allegations of physical abuse in Sample D.1 law enforcement notification occurred. In case 42212298 law enforcement notification was not documented in the DFPS case report.<br><br>Based on a review of five 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.<br><br>The Monitoring Team determined in its last review that the DSSLC was in substantial compliance with this component of the SA. The Facility remains in substantial compliance but needs to ensure that at least all allegations of physical abuse receive a law enforcement referral to remain in compliance at the next review. | |
| | (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. | Facility Self-Assessment:<br>The Facility engaged in the following activities in conducting its self-assessment of this Provision.<br>1. Random sample of 10 investigations was reviewed for potential retaliation.<br><br>From its self-assessment the Facility determined that:<br>1. Review 10 investigations (Random sample) from April 1, 2012 to September 5 2012, indicates no instances of retaliation were reported or discovered.<br><br>Based on the findings from this self-assessment, this provision remains in substantial compliance because there have been no instances of retaliation.<br><br>Monitoring Team note: the Facility self-assessment should include random staff interviews, discussion with the Facility Director, and discussion with DFPS and OIG investigators.<br><br>Monitoring Team Findings:<br>Based on interviews with the Director of Incident Management, and the Incident | Substantial Compliance |

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| | | 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.<br><br>In one investigation reviewed by the Monitoring Team a concern of perceived retaliation was noted. This was DFPS case 41945796. The Monitoring Team reviewed this with the Assistant Director of Programs who described the Facility response. The Facility's follow-up actions were satisfactory to the staff person who perceived retaliation. In this case several staff were reassigned, including administrative staff, to break up what was described as "cliques" that some staff felt led to favoritism in work assignments which then led some staff to feel they received less desirable assignments as retaliation for something they had said or done (not necessarily directly related to reporting an allegation).<br><br>The Monitoring Team interviewed an OIG Investigator who reported no concerns with retaliation.<br><br>As reported in Provision D.2.c, DCPs reported that if retaliation were to occur, or was suspected, the Facility administration would respond appropriately.<br><br>The Monitoring Team has determined that the DSSLC was in substantial compliance with this component of the SA. | |
| | (i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation. | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision.<br>1. Reviewed under reporting audit forms completed by quality assurance auditor.<br>2. Reviewed the results from the under reporting audit.<br><br>From its self-assessment the Facility determined that:<br>1. Audit form had been revised to include report of all significant non-serious injuries.<br>2. 48 of 52 (92%) of significant injuries had been reported.<br><br>Based on the findings from this self-assessment, this provision is in substantial compliance because the average of percentages for the above listed months for under reporting reflects a 92% rate, audits are completed on a monthly basis that include a determination whether significant injuries are reported for investigation.<br><br>Monitoring Team note: The Monitoring Team is concerned that the Facility apparently | Substantial Compliance |

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| | | views nearly one in ten significant injuries not being reported for investigation as an acceptable standard.<br><br><u>Monitoring Team Findings:</u><br>The Facility had a regular audit process in place to detect instances of unreported significant injuries. Since the last review the audit protocol was revised to address concerns presented by the Monitoring Team in the last report including:<br>• Determining whether or not an issue identified by a program auditor was representative of a "significant injury" because a significant injury may not necessarily be a serious injury as defined in DADS or Facility policy. For example, issues identified in audits could involve incidents/injuries that reported coughing (i.e. aspiration issue?), cuts (i.e. blood and infection control issue?), or injury in the area of the eye (client protection issue?). All these could be considered "significant" and should be closely scrutinized. The Facility Under Reporting Record Review Audit form now identifies any underreporting of significant injuries.<br>• Determining whether or not an issue identified by a program auditor was (or should have been) reported for investigation. The Facility Under Reporting Record Review Audit form now identifies whether or not significant injuries were reported for investigation.<br>• Determining if issues identified by a program auditor should have been reported for investigation, and were not, that discovery of this resulted in initiation of an investigation. The Facility Under Reporting Record Review Audit form now records this information.<br><br>In conducting audits the Facility reviews integrated progress notes, direct care staff observation notes, injury reports, and unit incident review team meeting minutes. The following questions are probed:<br>1. Were all incidents of choking, aspiration, client to client aggression, unauthorized departures, and abuse/neglect documented and reported?<br>2. Were all serious injuries documented and reported through the UIR process?<br>3. Were all non-serious injuries involving eyes, face, breast, buttocks, back and genitalia documented and reported?<br>4. Did staff document immediate action taken to protect the Individual?<br><br>In addition to generating administrative follow-up when problems are detected, data resulting from the audits is compiled and presented to the Facility QA/QI Council. In July the 13 completed audits reported 100% compliance with the first three questions and 62% compliance with question number four. | |

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| 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><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Reviewed Incident Management (IM) staff training records to determine all required training was completed by staff conducting investigations per state and local policy.<br>2. Reviewed training curriculum for all investigators including DFPS investigators.<br>3. Completed review to see if any investigator where in the direct line of supervision of an alleged perpetrator.<br><br>From its self-assessment the Facility determined that:<br>1. On 9/6/12, a review of the nine IM Staff training records indicates nine of nine staff that conducted investigations was properly trained. One staff is a new investigator and has completed all facility training required for a new investigator and is assigned to attend the additional training in October 2012 which is within appropriate time frame. He is not completing investigations independently until he receives all training.<br>2. All investigators are in compliance with training requirements.<br>3. No investigations were completed by investigators within the direct line of supervision of an alleged perpetrator.<br><br>Based on the findings from this self-assessment, this provision remains in substantial compliance because all staff that conducts investigations received the training required within the six month period of hire as noted in the state and local policy.<br><br>Note: the Facility's self-assessment was incomplete as it did not address all required elements of the SA; for example, the Facility's self-assessment did not review training curriculum and training completion for DFPS investigators. | Substantial Compliance |

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| | | Monitoring Team Findings:<br>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 (the training provided under contract with Labor Relations Alternatives), and a class in Root Cause Analysis. The policy required that investigators have training in working with people with developmental disabilities, including persons with mental retardation. This was accomplished through successful completion of People with MR (MEN0300). The Monitoring Team believes this training, if completed as described, should be adequate for the conduct of investigations at DSSLC.<br><br>Finally, the Facility policy required that investigators be outside of the direct line of supervision of alleged perpetrators.<br><br>The Monitoring Team reviewed material used by DFPS in training its investigators. The required class "MH&MR Investigations ILSD" consisted of the following modules:<br>1. Introduction and History of DFPS, APS, DADS, and DSHS<br>2. Laws, Rules, & Policies Governing APS MH&MR Investigations<br>3. Dynamics of Abuse, Neglect, and Exploitation<br>4. Psychiatric Terms<br>5. Client Rights<br>6. Prevention and Management of Aggressive Behavior<br>7. Evidence Collection<br>8. Basic Interviewing<br>9. Interviewing Persons with Developmental Disabilities<br>10. MH&MR IMPACT Technical Guide<br>11. Analysis of Evidence<br>12. Effective Writing<br>13. Disposition of Cases<br><br>The required class MH&MR Investigations ILASD included the following modules:<br>1. Cross-Cultural Interviewing<br>2. Strengthening the Written Report<br>3. Deception and Confrontation of Deception<br>4. Time and Stress Management<br><br>In reviewing the materials associated with these modules the Monitoring Team is of the opinion that this training was competency-based.<br><br>DFPS reports its investigators are to have completed APS Facility BSD 1 & 2, or MH &MR | |

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| | | 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.<br><br>DFPS had six investigators assigned to work DSSLC cases. The training records for these investigators were reviewed. All six (100%) had completed the requirements for investigations training.<br><br>DSSLC had nine staff designated as investigators. The training records for these staff were reviewed. All nine had completed the required training.<br><br>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.<br><br>The Monitoring Team has determined that the DSSLC was in substantial compliance with this component of the SA. | |
| | (b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation. | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Reviewed investigations (random sample) to determine if staff cooperated with outside entities during investigations.<br><br>From its self-assessment the Facility determined that:<br>1. Review of 10 investigations from 4/1/12 to 9/5/12 indicates 10 of 10 (100%) showed that staff cooperated with outside entities during ANE investigations.<br><br>Based on the findings from this self-assessment, this provision remains in substantial compliance because there were no instances where staff did not cooperate with outside entities conducting investigations.<br><br>Monitoring Team note: In its last report the Monitoring Team noted that 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. No action was reported by the Facility in this regard. The Facility also convenes period meetings with outside investigators. This topic could be on the agenda for those meetings.<br><br><u>Monitoring Team Findings:</u> | Substantial Compliance |

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| | | The Monitoring Team did not find any instances of lack of cooperation in its review of the 13 DFPS investigations in Sample D.1.<br><br>Additionally, the Monitoring Team interviewed one OIG investigator who reported excellent levels of cooperation by facility staff.<br><br>In its last report the Monitoring Team noted that Facility policy did not specifically address this subject and suggested it might be appropriate in the DSSLC assurances section of the policy, or the state center investigations section of the incident management policy to include:<br>• 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.<br>• 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.<br>• Language that makes it known that staff failure to cooperate with an investigation will result in disciplinary action.<br><br>The Monitoring Team again asks that the Facility consider such changes when it revises this policy.<br><br>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><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Review of the local policy to determine policy supports the coordination of investigations.<br>2. Reviewed investigations to determine investigations were coordinated as to not interfere with such investigations.<br><br>From its self-assessment the Facility determined that:<br>1. In September, review of local policy shows that policy supports appropriate coordination of investigations between agencies as not to interfere with such investigations<br>2. Review of 10 investigations(Random sample) from 4/1/12 to 9/5/12 reflect 10 of 10 investigations(100%) show that investigations were coordinated as to not interfere with such investigations. | Substantial Compliance |

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| | | Based on the findings from this self-assessment, this provision remains in substantial compliance because all of the reviewed investigations were coordinated as to not interfere with such investigations.<br><br>Monitoring Team note: In its last report the Monitoring Team noted that 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. No action was reported by the Facility in this regard.<br><br><u>Monitoring Team Findings:</u><br>A Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency."<br><br>Based on a review of the 13 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.<br><br>Of the six investigation records from the Facility (Sample 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.<br><br>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><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision.<br>1. Reviewed local policy and evidence storage to ensure it supports the safeguarding of evidence.<br>2. Reviewed investigations to determine if evidence was safeguarded if needed. | Substantial Compliance |

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| | | From its self-assessment the Facility determined that:<br>1. Evidence is being safe guarded according to policy. Only the Director of IM and the IMC have keys to evidence cabinet and it is locked in IMC office.<br>2. Review of a random sample of 10 investigations from 04/01/2012 to 09/05/2012, indicates 10 of 10 investigations (100%) had no evidence to secure.<br><br>Based on the findings from this self-assessment, this provision remains in substantial compliance<br>Because there was no physical evidence to safe guard or evidence was safeguarded per policy.<br><br><u>Monitoring Team Findings:</u><br>Exhibit B to policy CMGMT 01B Incident Management (7/1/11) provides specific guidelines for safeguarding physical evidence.<br><br>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 of the investigations completed by DFPS (Sample D.1) and the Facility (Sample D.2) any physical evidence that needed to be safeguarded was. Additionally, upon interview the OIG investigator reported no issues related to the safeguarding of physical evidence.<br><br>This Provision is in substantial compliance. | |
| | (e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision.<br>1. Review of investigations to determine if all incidents commenced within 24 hours<br>2. Reviewed investigations to see if they were completed in 10 calendar days.<br>3. Reviewed investigations to see if because of extraordinary circumstances the SSLC Director or Adult Protective Services Supervisor grants written extension<br>4. Reviewed investigations for written report<br>5. Reviewed investigations to see if they included summary of the investigation, findings, and recommendations.<br><br>From its self-assessment the Facility determined that:<br>1. Review of a random sample of 10 investigations from 5/1/12 to 9/1/12 indicates 8 of 10 investigations (80%) commenced within 24 hours.<br>2. Review of a random sample of 10 investigations from 5/1/12 to 9/5/12 indicates 9 of 10 (90%) were completed in 10 calendar days<br>3. Review of a random sample of 10 investigations from 5/1/12 to 9/5/12 indicates 1of 1requiring an extension (100%) had an extension filed. | Noncompliance |

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| | | 4. Review of a random sample of 10 investigations from 5/1/12 to 9/5/12 indicates 10 of 10 (100%) had a summary of findings<br>5. Review of a random sample of 10 investigations from 5/1/12 to 9/5/12 indicates 10 of 10 (100%) included recommendations for corrections.<br><br>Based on the findings from this self-assessment, this provision is not in substantial compliance because there are two instances (20% of the sample taken) where the investigation did not commence within 24 hours.<br><br>Monitoring Team note: the self-assessment does not differentiate between DFPS investigations and Facility investigations. This needs to occur in order to identify the source of any problems and the appropriate corrective action.<br><br><u>Monitoring Team Findings:</u><br>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.<br><br>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.<br><br><u>DFPS Investigations</u><br>The Monitoring Team reviewed the DFPS document provided by DADS, which was 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. These guidelines did not require DFPS presence at the Facility within 24 hours of an incident being reported except in instances of Class I physical abuse and sexual abuse allegations. Very few allegations are classified as Class I even though it appears many could be because the definition of Class I includes abusive acts that "could have" resulted in serious injury. It appears that in practice only abusive acts that did result in serious injury are classified as Class I although there are very limited examples of this occurring.<br><br>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. The Monitoring Team believes the initial plan for investigations (which must be done within the first 24 hours) should include an assessment of the need to protect testimonial evidence. If this assessment determines that protection of testimonial evidence is critical to the | |

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| | | investigation, then DFPS and the Facility should be expected to agree on any special administrative efforts the Facility or DFPS should undertake to accomplish this. The DFPS office which services this Facility had taken one positive step in regard to the protection of testimonial evidence. Eleven of the 13 investigation in Sample D.1 occurred after April, 2012. All contained the following language in the narrative describing commencement activity: "Investigator John Doe directed the facility to protect Mr. Bill Doe and the evidence; including taking appropriate steps to ensure the alleged perpetrator and witnesses do not discuss the investigation." It is possible that more explicit conversation occurs between the DFPS investigator and the Facility in this regard that does not get recorded in the investigation report and this standard text is used to document the fact explicit conversation did occur. The Monitoring Team looks forward to probing this further at the next review, including what, if anything, the Facility specifically does in response to this DFPS recommendation.<br><br>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. All 13 (100%) cases in Sample D.1 documented these type of activities took place within the first 24 hours.<br><br>All 13 (100%) were completed within 10 calendar days of the report of the incident.<br><br>All 13 (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.<br><br>DFPS concerns and recommendations for corrective action were included in four investigation reports and were appropriate to address issues identified by the DFPS investigator.<br><br><u>Facility Investigations (Sample D.2)</u><br>The following summarizes the results of the review of Facility investigations of serious injuries:<br><br>Five of five (100%) commenced within 24 hours or sooner, if necessary. This was | |

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| | | determined by reviewing the UIR and determining the time of the first entry indicating any on site work activity by a facility investigator.<br><br>Four of five (80%) were completed within 10 calendar days of the incident (or had an approved extension), including sign-off by the supervisor. UIR 236 did not.<br><br>Five of five (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are presented in Provision D.3.f of this report.<br><br>In all five of the investigations reviewed (100%), recommendations for corrective action were included. In all five of the investigations (100%), the recommendations appeared adequate to address the findings of the investigation although in three (60%) the investigation report did not contain an explicit determination that abuse or neglect was, or was not, the cause of or a contributing factor to the serious injury. This determination is a key component of an investigation of a serious injury. This was missing from UIRs 212, 261, and 236. Without this determination an investigation of a serious injury cannot be considered thorough and complete.<br><br>The Monitoring Team concurs with the Facility self-assessment that it is not in substantial compliance with this Provision.<br><br>To achieve compliance with this component of the SA Facility investigations must include an explicit determination that abuse or neglect was, or was not, the cause of or a contributing factor to the serious injury and this determination resulted in recommendations for corrective action.<br><br>Additionally, it should be noted that the Facility assessment reported 80% compliance with the requirement for 24 hour commencement of an investigation and the Monitoring Team sample reported 100% compliance. | |
| | (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 | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Reviewed investigations to determine if all investigations provided a clear basis for its conclusion and that each serious incident or allegation of wrongdoing includes the names of all witnesses, the names of the alleged victims and perpetrators, names of all people interviewed, and accurate summary of topics discussed, a recording of the witness interview and a summary of material statements made, as well all documents reviewed and all sources of evidence considered and the investigator's findings and their reasons for their conclusions. | Noncompliance |

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| | 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. | 2. Primary reviewers discussed overall review of investigations.<br><br>From its self-assessment the Facility determined that:<br>1. Review of 10 investigations(Random sample) from 4/1/12, to 9/5/12 indicates that 10 of 10 investigations (100%) provided a clear basis for its conclusion and that each serious incident or allegation of wrongdoing includes the names of all witnesses, the names of the alleged victims and perpetrators, names of all people interviewed, and accurate summary of topics discussed, a recording of the witness interview and a summary of material statements made, as well all documents reviewed and all sources of evidence considered and the investigator's findings and their reasons for their conclusions.<br>2. All primary reviewers indicated that although improvement had been made, they were still finding problems in the conclusions and other components of the reports.<br>Based on the findings from this self-assessment, this provision is not in substantial compliance because all investigations do not provide a clear basis for conclusions and the investigators' reasons for their conclusions.<br><br>Monitoring Team note: the self-assessment text in #1 and #2 above appears contradictory. Future self-assessments should be more explanatory.<br><br><u>Monitoring Team Findings:</u><br>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 explicitly and separately:<br>• Each serious incident or allegations of wrongdoing;<br>• The name(s) of all witnesses;<br>• The name(s) of all alleged victims and perpetrators;<br>• The names of all persons interviewed during the investigation;<br>• 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;<br>• All documents reviewed during the investigation;<br>• All sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency;<br>• The investigator's findings; and<br>• The investigator's reasons for his/her conclusions.<br><br>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 | |

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| | | 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.<br><br><u>DFPS Investigations</u><br>The following summarizes the results of the review of DFPS investigations:<br><br>In 12 of 13 investigations reviewed (92%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. Case 42212298 did not. This was an allegation of physical abuse reported by an employee of a local fast food restaurant that was alleged to occur in the dining room of the restaurant. After investigation DFPS returned an unconfirmed finding primarily because when the investigator called the restaurant manager seeking to speak to the reporter the investigator was told no one by that name worked at the restaurant. Therefore there was no credible witness.<br><br>When the Facility conducted its standard review of the DFPS investigation report it quickly determined the DFPS investigator selected the wrong restaurant (same name but different location) to pursue the investigation. Upon interview the alleged perpetrator identified the location of the restaurant (while denying the abuse) but the DFPS investigator did not figure out that the location she called was different than the location where the event actually occurred, as reported by the alleged perpetrator. This particular restaurant chain has some sites with only curbside service and others with curbside service and inside dining. The alleged perpetrator in her interview was clear they (two staff) went "inside the dining room." The site contacted by DFPS did not have inside dining. The Facility chose to conduct its own follow-up investigation rather than ask DFPS to conduct additional investigation activity associated with the allegation. The Facility investigation, at the correct restaurant site, included an interview with an eyewitness, resulted in confirmation and personnel action being taken with the two employees involved, one who committed the abuse and the other who was aware of it and didn't report it.<br><br>DFPS reports utilized a standardized format that set forth explicitly and separately<br>• In 13 (100%), each serious incident or allegations of wrongdoing;<br>• In 13 (100%), the name(s) of all known witnesses;<br>• In 13 (100%), the name(s) of all alleged victims and perpetrators;<br>• In 13 (100%), the names of all persons interviewed during the investigation;<br>• In 13 (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;<br>• In 13(100%), all documents reviewed during the investigation; | |

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| | | • In 13 (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;<br>• In 13 (100%), the investigator's findings; and<br>• In 13 (100%), the investigator's reasons for his/her conclusions although as reported above not always correctly.<br><br><u>Facility Investigations</u><br>The following summarizes the results of the review of Facility investigations:<br>• In two of five investigations reviewed (40%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. Those that were not were UIR 186, 261, and 236. As reported in Provision D.3.e these investigations of serious discovered injuries did not include a determination as to whether or not abuse or neglect was a cause or contributing factor of the injury. The investigation should have made a conclusion one way or the other.<br>• The investigation of the serious discovered injury (fracture) recorded in UIR 186 stated "proper procedures and techniques appeared to be in place during the transfer." This statement was made by a security camera monitor and apparently accepted as fact. The conclusion offered by the security camera monitor was not independently corroborated by someone clinically competent to draw such a conclusion, for example, PNMP staff.<br>• In all five investigations the UIR cover sheet reports the discovered serious injury as having a "determined cause" when in fact in no case was sufficient evidence present to draw such a conclusion. In each case the development of plausible hypotheses are presented apparently because the investigator could not determine any other explanation for the injury or did not complete a thorough investigation. For example, the injury report associated with UIR 261 reports the probable cause as "she fell on the mat from her bed." The investigation was incomplete and did not include any video review to determine who may have gone in and out of her room (and could have perpetrated or witnessed the event that resulted in the serious injury) nor were any staff interviews conducted to try and establish the last time the Individual was observed without the injury. It appears too often investigators search for a plausible explanation for the serious discovered injury rather than conduct a thorough and complete investigation.<br>• Finally, issues associated with specific staff assignments and responsibilities associated with supervision and care of Individuals were rarely probed in investigations of serious discovered injuries. When probable cause cannot be determined based on evidence the Facility should at least suspect neglect with respect to supervision, adequate treatment, and client protections. | |

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| | | • Reports utilized a standardized format that set forth explicitly and separately<br>o In five (100%), each serious incident or allegations of wrongdoing.<br>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.<br>o In five (100%), the name(s) of all alleged victims and perpetrators.<br>o In five (100%), the names of all persons interviewed during the investigation.<br>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:…..". Most UIR's used terms like "Investigator John Doe talked with …..", or "John Doe provided a witness statement." It was not clear from these types of statements who was actually interviewed by an investigator, what topics were covered in the interview, and what material statements relevant to the investigation were obtained from the interview.<br>o In five(100%), all documents reviewed during the investigation;<br>o In five(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<br>o In five (100%), the investigator's findings although as noted earlier the findings are not always complete and thorough; and<br>o In five (100%), the investigator's reasons for his/her conclusions although as noted earlier the reasons are not always complete and thorough.<br><br>The Monitoring Team concurs with the Facility self-assessment that it is not in substantial compliance with this Provision. | |
| | (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 | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Reviewed investigations to see if review by supervisor was completed.<br>2. Reviewed investigations to see if review resulted in changes needed.<br>3. Primary reviewers discussed overall review of investigations. | Noncompliance |

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| | 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. | From its self-assessment the Facility determined that:<br>1. Review of investigations from 5/1/12 to 9/5/12 (random sample) indicates that 10 of 10 investigations (100%) were reviewed by the supervisor to ensure investigations are complete and accurate.<br>2. Review of investigations from 5/1/12 to 9/5/12 (random sample) showed that changes were needed and made.<br>3. All primary reviewers indicated that although improvement had been made, they were still finding problems in secondary review of investigations.<br><br>Based on the findings from this self-assessment, this provision is not in substantial compliance because, although supervisory review is occurring for all investigations, the reports still have room for improvement.<br><br>Note: In its last report the Monitoring Team noted that 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. It does not appear the Facility initiated any self-assessment activity to address this. Additionally, when a statement in a conclusion is "reports still have room for improvement" more specificity should be provided that can lead to corrective activity that can be incorporated in the companion Action Plan.<br><br><u>Monitoring Team Findings:</u><br>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.<br><br>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.<br><br><u>DFPS Investigations</u><br>The following summarizes the results of the review of DFPS investigations:<br><br>Thirteen of 13 (100%) case files reviewed contained evidence that the DFPS supervisor had conducted a review of the investigation report. In one (8%) concerns were identified by the Monitoring Team (refer to Provision D.3.f) that should have been detected | |

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| | | through the DFPS supervisory review.<br><br>In all 13 (100%) case files, there was evidence that the DSSLC Incident Manager Coordinator had conducted a review of the investigation report. The Facility process for review of DFPS investigation reports had substantially improved compared to what was observed at the last review. The Facility provided examples of problems it identified with DFPS reports. For example the Facility in reviewing DFPS case 42360056 (unfounded abuse) noted that all potential witnesses were not interviewed. DFPS came back out to the Facility and conducted additional interviews (this did not result in a change in case disposition). With DFPS case 41945796 (unconfirmed abuse) the Facility also noted that all potential witnesses were not interviewed. DFPS did not conduct additional interviews in this case. The Facility interviewed an additional 12 staff as potential witnesses but did not develop sufficient evidence to change the DFPS disposition. Much of this review activity occurred when the Review Authority conducts its review of investigation reports. The Review Authority consisted of the Facility Director, Assistant Director of Programs, Director of Residential Programs, the Director of Incident Management, and the Incident Management Coordinator. The purpose of this group is to conduct thorough review of each DFPS case report by executive team members 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. The Facility is to be commended for its improvement in reviewing DFPS investigations.<br><br><u>Facility Investigations</u><br>The following summarizes the results of the review of Facility investigations:<br>• In all five investigation files reviewed (100%) there was evidence that the supervisor of investigations had conducted a review of the investigation report.<br>• In all five (100%), 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.<br><br>The Monitoring Team concurs with the Facility self-assessment that it is not in substantial compliance with this Provision. | |
| | (h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident. | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Reviewed investigations to determine that each case has a written report per the provisions of subparagraph g.<br>2. Reviewed investigations to determine if report documents actions taken.<br>3. Reviewed self-assessment of D.3.g. | Noncompliance |

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| | | From its self-assessment the Facility determined that:<br>1. Review of 10 investigations (Random sample) from 4/1/12 to 9/15/12 reflects 10 of 10 investigations (100%) had a written report.<br>2. Reviews of a Random sample of 10 investigations result in all investigations have actions taken documented.<br>3. Reviewed results of self-assessment for D.3.g<br><br>Based on the findings from this self-assessment, this provision is not in substantial compliance because improvement is still needed in D.3.g.<br><br>Monitoring Team note: In its last report the Monitoring Team reported that the Facility's self-assessment was incomplete as it did not address all required elements; 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 did not appear to be assessed by the Facility in this self-assessment. Additionally, when a statement in a conclusion is "improvement is still needed" more specificity should be provided that can also be incorporated in the companion Action Plan.<br><br><u>Monitoring Team Findings:</u><br>The Monitoring Team identified three separate review forms used in documenting investigation review in case files. Each could be viewed as relevant to compliance with this Provision. These were:<br>1. DSSLC Incident Management Team Review of DFPS Investigations. This form documented review of each DFPS investigation report by the Facility's Review Authority described in policy. The scope of responsibility for this group had expanded to include review of all UIRs.<br>2. DSSLC Incident Management Team Review of DFPS Investigations. The IMRT also reviews each DFPS case report and each UIR.<br>3. Investigation Review/Approval Form. This form is used by the IMC to validate incident management supervisory review of UIRs. Those reviewed by the Monitoring Team showed that the results from this review primarily correct typographical errors and misspellings.<br><br>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 investigation reports, particularly Facility investigations of serious discovered injuries. As reported in Provision D.3.g, | |

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| | | Facility review activity did not identify any of these issues in any of these cases.<br><br>The Monitoring Team concurs with the Facility self-assessment that it is not in substantial compliance with this Provision.<br><br>The written reports provided to the Monitoring Team were insufficient to demonstrate compliance 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><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Reviewed Incident Management Tracking (IRMT) Log to ensure that disciplinary and programmatic actions were documented<br>2. Review of all incidents from 4/1/12 to 8/31/12 to see if recommended actions occurred.<br>3. Review of all incidents from 4/1/12 to 8/31/12 to see if recommended actions prevented recurrence.<br><br>From its self-assessment the Facility determined that:<br>1. Reviewed the IRMT tracking log from 4/1/12 to 9/5/12 and all recommendations from all incidents are documented in the log.<br>2. Review of all incidents from 4/1/2 to 8/31/12 indicated that not all actions had documentation to prove completion however all were being tracked to completion.<br>3. Review of all incidents from 4/1/12 to 8/31/12 indicated that there has not been any reoccurrence of similar incidents.<br><br>Based on the findings from this self-assessment, this provision is not in substantial compliance because, although actions put in place have prevented reoccurrence, documentation was not available for all actions.<br><br>Monitoring Team 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. Additionally, in assessing completion of disciplinary or programmatic actions the Facility apparently relied on reviewing tracking logs without reviewing, at least on a sample basis, source documentation to validate the intended action occurred.<br><br><u>Monitoring Team Findings:</u> | Noncompliance |

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| | | 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.<br><br>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.<br><br>In its last report the Monitoring Team noted that the Facility did not appear to have any mechanism to assess 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 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? The Facility's view of "recurrence" was apparently limited to recurrence by the offending employee. The Facility did not engage 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 expects the Facility to collect data on similar types of problems and determine if the corrective actions put in place have prevented (or limited) recurrence. From this review it did not appear the Facility made any progress in this area.<br><br>Case files reviewed by the Monitoring Team included copies of all relevant disciplinary action taken in response to investigation findings.<br><br>The Monitoring Team concurs with the Facility self-assessment that it is not in substantial compliance with this Provision.<br><br>The Monitoring Team believes in order to achieve substantial compliance, additional effort is required to track and document corrective 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 | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision: | Substantial Compliance |

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| | that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual. | 1. Evaluated our current record storage area for investigations for easy accessibility.<br><br>From its self-assessment the Facility determined that:<br>1. After evaluation of record area it is concluded that the current area/system is efficient, restricted and meets the requirements.<br><br>Based on the findings from this self-assessment, this provision remains in substantial compliance because system allows investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.<br><br><u>Monitoring Team Findings:</u><br>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.<br><br>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.<br><br>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><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Reviewed 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.<br><br>From its self-assessment the Facility determined that:<br>1. Trend reports reflect the above data changes and continues to include longitudinal data<br><br>Based on the findings from this self-assessment, this provision is in substantial compliance because trends reports are 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 and includes longitudinal data.<br><br><u>Monitoring Team Findings:</u> | Noncompliance |

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| | | Facility data reports a significant increase (quarter to quarter) in the number of DFPS allegations (58 to 64 to 83) but the trend line for confirmed cases was showing fewer confirmed cases.<br><br>The Facility had made improvements in its Trend Report, most notably in tracking data longitudinally. In its last report the Monitoring Team noted that 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. Some additional data in this regard has been added to the Facility Trend report but further refinement is needed in content and presentation such that it can display trends in certain key areas, such as those enumerated above. Particularly with respect to confirmed cases of abuse and neglect it would be useful to track and trend data by the location of the incident that resulted in the confirmed finding, and, by the shift that the incident occurred during. This would presumably contribute to a data based understanding of when and where abuse and neglect has occurred. Trend data should be presented in a manner that lends itself to useful discussion and decision-making.<br><br>At the present time the Facility's Incident Management Department did not use much of the available data to analyze client protections at the Facility. Its use of data was limited to management oversight activity within the Department such as tracking IMRT directed follow-up. This is necessary but should not be the only focus of data utilization. There were no examples presented to the Monitoring Team that demonstrated analyses of data leading to subsequent decision-making.<br><br>To achieve compliance with this Provision the Facility needs to not only track the results of investigations of incidents and allegations but also present data in a manner that lends itself to useful discussion and decision-making. The Facility must also demonstrate it is using these data to assess operational performance, to improve deficient practices, to improve client protections, and to improve services.<br><br>The Monitoring Team does not concur with the Facility self-assessment of substantial compliance. | |

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| 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><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Initial and annual checks with Employee Misconduct Registry, the Nurse Aide Registry, the Client Abuse and Neglect Reporting System, and the Federal Bureau of Investigation for employee fingerprints are conducted for 100% of applicants, employees, and volunteers. This occurs during the initial involvement with the SSLC and annually thereafter.<br><br>From its self-assessment the Facility determined that:<br>1. All of the 1625 current employees and volunteers do not have, as a result of any of the checks performed, any permanent bars to employment. Since the last monitoring review, there have been (0%) of people who had discretionary bars to employment. The Director has exercised a decision making process to determine if they may continue with employment or volunteering.<br><br>Based on the findings of this self-assessment, the provision is in substantial compliance because 100% of the current employees and volunteers do not have a criminal history that would preclude them from working or volunteering in an SSLC.<br><br>Monitoring Team note: the self-assessment does not address other administrative activity necessary for determining compliance with this provision such as employee self-reporting of arrests and administrative response.<br><br><u>Monitoring Team Findings:</u><br>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.<br><br>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. | Substantial Compliance |

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| | | Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. The most recent check was completed in October, 2012 and provided to the Monitoring Team. Employees were subject to a one-time fingerprint check during the month of October, 2011. Once the fingerprints were entered into the system, the Facility receives 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.<br><br>Facility policy requires employees to self-report encounters with law enforcement that may impact their continued eligibility for employment. The State also provided similar information to the Facility as cross-matches routinely occur between state employee records and background check databases. This process identifies employees who did not self-report law enforcement encounters. The Facility Director confirmed this process, as described, is in place at the Facility.<br><br>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. (Provision D.3.f)
3. Improve the effectiveness of Facility review of Facility investigations to ensure investigations were complete, thorough, and drew reasonable conclusions based on evidence. (Provision D.3.g and D.3.h)
4. Improve Facility investigations of non-serious discovered injuries to rule out abuse and neglect including thorough identification and examination of all sources of evidence, including interviews of potential witnesses where warranted, and review of video surveillance tapes when available. (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 also over time as occurs with other data elements in the report. Report both numerical counts and graphs. (Provision D.4)

| SECTION E: Quality Assurance | |
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| 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:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment 9/24/12<br>2. DSSLC Action Plan 9/24/12<br>3. DSSLC Section E Presentation Book<br>4. DADS Policy 003.1 - Quality Assurance 1/26/12<br>5. DSSLC Policy CMGMT-15 Quality Assurance 9/1/12<br>6. DSSLC QA Plan 9/4/12<br>7. DSSLC Policy C&C-02 Quality Assurance/Quality Improvement Council 9/6/11<br>8. Quality Assurance/Quality Improvement Council Meeting: Data Analysis Report April, 2012 through October, 2012<br>9. Quality Assurance/Quality Improvement Council meeting minutes April, 2012 through September, 2012<br>10. Monitoring tools and guidelines for each provision of the SA (various dates)<br>11. Allegations Trend Report 8/12<br>12. Unusual Incidents Trend Report 8/12<br>13. Restraint Trend Report 8/12<br>14. Injury Trend Report 8/12<br>**People Interviewed:**<br>1. Lori Powell, Director of Quality Assurance<br>**Meetings Attended/Observations:**<br>1. Incident Management Review Team (IMRT) 10/11/12<br>2. Restraint Reduction Committee 10/10/12<br>3. Quality Assurance/Quality Improvement Council (QA/QI Council) meeting 10/9/12 |
| | **Facility Self-Assessment:**<br>The Facility self-assessment did not report substantial compliance with any Provision in Section E. The self-assessment was very similar to that presented for the last compliance visit and focused primarily on the 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 self-assessment provided very limited data associated with the use of data to determine the need to develop Corrective Action Plans (CAPs). The self-assessment did not address the analysis and use of data for decision-making or for the identification of systemic issues facing the Facility.<br><br>The Facility's Action Plan that accompanied the self-assessment included steps to improve processes that would lead to compliance with the Settlement Agreement. For example, an action step was initiated to strengthen the content of monitoring tools, including consideration of weighting certain questions. A second example is initiating an action step to organize the Corrective Action Plan database such that it could better identify similar issues that might suggest a systemic issue needs to be addressed. |

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| | Most of the self-assessment activity, and more importantly the findings, were identical to that which was presented for the previous review. This may suggest a lack of progress during the last six months in achieving compliance with this Section of the SA.<br><br>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:**<br>The work effort observed during this monitoring visit demonstrated continued improvement in the development and implementation of some components of an effective QA system although much remains to be done.<br><br>Since the last review the Facility had updated its policy CMGMT-15 Quality Assurance (9/1/12) and its Quality Assurance Plan (9/4/12). The Facility reported it had added clinical indicators to its QA program The Facility provided a list of 72 topics for which it collects and reports data on clinical indicators. The Facility reported 43 of these had been added to its QA program since the last review.<br><br>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.<br><br>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.<br><br>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 regularly reviewed in the QA/QI Council.<br><br>The process for inter-rater reliability made progress since the last review. Data tables and graphs presented in the monthly QA/QI Council report included inter-rater reliability data.<br><br>In the last review it was noted the Facility had put a system in place for the development, implementation, and tracking of corrective action plans (CAPs). This system is supported with a database. Implementation was limited.<br><br>The Facility was unable to describe any process to determine if a CAP was effective in remedying or reducing the problems originally identified.<br><br>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. |

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| | 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 clinical and treatment issues that may be related to effective interdisciplinary review of individual issues that could also point to possible systemic issues related to the manner in which clinical departments communicate with one another.. |

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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:<br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Reviewed longitudinal data.<br>2. Reviewed the Quality Assurance/Quality Improvement (QAQI) Council meeting minutes to determine if the Council meets at least monthly.<br>3. Reviewed QAQI Council meeting minutes to determine if the Council is reviewing the incident management data quarterly.<br>4. Reviewed the QAQI Council meeting minutes to determine if the Council is reviewing the restraint data quarterly.<br>5. Reviewed the QAQI Council meeting minutes to determine if the Council is reviewing the POI section monitoring quarterly.<br>6. Reviewed the QAQI Council meeting minutes to determine if corrective actions are needed and/or identified.<br>7. Review of the QA Plan to determine that it accurately reflects ongoing monitoring.<br>8. Reviewed Quality Indicators to determine that monthly data is collected timely and shared with the QAQI Council quarterly.<br>9. Reviewed with each Section Lead all monitoring tools to eliminate duplicate questions or tools.<br><br>From its self-assessment the Facility determined that:<br>1. The longitudinal data has been expanded in the following sections: ISP Assessment data, Engagement/Active Treatment data, Trends Analysis data, Oral Hygiene data, and Late Reporting data.<br>2. Since the April independent monitoring visit the QAQI Council met twice in April, once in May, twice in June, twice in July, twice in August, and scheduled to meet twice in September, thus meeting the requirement for meetings to be held at least monthly.<br>3. The QAQI Council meeting minutes indicate the Council is reviewing the incident management data quarterly.<br>4. The QAQI Council meeting minutes indicate the Council is reviewing the | Noncompliance |

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| | | restraint data quarterly.<br>5. Since the September court monitor visit the QAQI Council reviewed the following POI monitoring:<br>4/17/12 – Sections G, H, L, I, J, M, O, P, Q<br>5/15/12 – Sections F, M, R, S, T, U, V<br>6/26/12 – Sections C, D, E, K, M, N<br>7/17/12 – Sections G, H, I, J, L, M, O, P, Q<br>8/24/12 - Sections E, F, M, R, S, T, U, V<br>The current schedule for quarterly review is being followed to ensure all sections are reviewed quarterly.<br>6. Since the April court monitor visit the QAQI Council has reviewed corrective action plans submitted at the time of the QAQI Council meeting. Since the April court monitor visit the QAQI Council reviewed the Quality Assurance Plan at 2 of 5 meetings as it was updated to reflect the recent revision to monitoring as agreed by QA and the department.<br>7. The Quality Assurance Plan is includes all Sections of the Settlement Agreement that is being monitored by the various Departments and by the Quality Assurance Department.<br>8. Since the development of the Key/Quality Indicators the QAQI Council reviewed them for accuracy and/or revisions in 5 of 5 meetings.<br>9. No longer using Monitoring tools for Sections F, S, and U. New Integrated ISP tools were implemented to include questions from Sections C, D, F, G, H, I, K, O, P, R, S, T, U, and V.<br><br>Based on the findings from this self-assessment, this provision is not in substantial compliance because the expanded format has had insufficient time to track data longitudinally across the various departments.<br><br>Monitoring Team note: the information presented, and conclusions reached, in this self-assessment is virtually identical to that provided in the last self-assessment six months ago leaving the Monitoring Team to question the degree to which any significant progress had been achieved.<br><br><u>Monitoring Team Findings:</u><br>Since the last review the Facility had updated its policy CMGMT-15 Quality Assurance (9/1/12) and its Quality Assurance Plan (9/4/12). The Facility reported it had added clinical indicators to its QA program. The Facility also reported it had begun a significant project to both improve the quality and timeliness of assessments used in ISP planning. Initial data from both initiatives was encouraging. The Facility reported that since the last review it had expanded longitudinal data tracking in some new areas, for example, ISP assessment data, oral hygiene data, and engagement/active treatment data. | |

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| | | 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: The composition of the QA/QI Council was multi-disciplinary and all meetings were well attended. A report was prepared for presentation at the meeting that included quantitative monitoring data on several provisions of the SA. These reports were generated from Monitoring Tool data. The work of the QA/QI Council was 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 was also reviewed in the QA/QI Council meeting. 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. Meeting minutes were organized around Settlement Agreement Provision headings. The meeting minutes template for each Section of the SA included a space to record the discussion that took place, the challenges presented, a recording of committee recommendations, and a section to record action steps and follow-up. The quality of information recorded using this format was variable. For example, in some cases the action/follow-up was noted as "CAPS were presented and disseminated." This statement is vague and not likely helpful weeks or months later when trying to assess what was happening to address compliance. A better example was an action/follow-up noted as "there is no change in the level of care delivered by psychiatry department since the last monitoring visit. No changes in action plans are recommended until data is obtained from the new audit tool." This is more descriptive and more informative to Council members.<br><br>In its last report the Monitoring Team commended the Facility for revising some trend data that is required in monthly reporting to DADS to include longitudinal data and suggested more detailed longitudinal tracking would likely be useful. No changes in presentation of trend data were noted during this review. Detailed longitudinal data may be useful in detecting systemic problems, or in concluding a particular problem appears to be limited in scope (as opposed to Facility-wide). For example, as reported in Provision D.4 the Allegations Trend Report reported the day of the week, shift, and hour of the day for allegations for the report month. It would 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 | |

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| | | windows, it is conceivable that activity schedules, staffing ratios, or supervisory presence may need to be examined. At a minimum these data, when reviewed longitudinally, should give clues as to administrative and programmatic processes that may need to change because data is pointing to a systemic problem. A similar approach to data presentation and analysis would be appropriate for injury trending and many other aspects of client protection, nursing care, and clinical outcomes.<br><br>The Facility collected and reported a great deal of data. Its data system was capable of manipulating data sets just about any way imaginable. It did not appear that enough effort had gone into developing report formats that present data in a way that could be used to drive meaningful analytical discussions. The Facility prepared a lengthy (approximately 40 pages) data report every month. At the QA/QI Council meeting observed by the Monitoring Team these data were presented to the group primarily as a matter of information. The information provided interesting data, certainly, but for the most part it was devoid of summary analysis pointing to administrative and/or clinical issues needing attention. The QA/QI Council seemed to spend a great deal of time reviewing data reports (numbers) and very little time constructively and critically thinking how those data could be used to identify problem areas needing attention, including the inter-relatedness of some data. For example, data reporting improved active treatment and behavior program implementation could have a correlated positive impact on data reporting restraint use and peer-to-peer injuries. Because of the interdisciplinary composition of this group it presented an excellent opportunity for various departments to assess how their work affects, or potentially affects, the problem (or set of problems) under review and discussion.<br><br>The Facility reported it had a more formal process for inter-rater reliability from that observed previously. Many monitoring tools were now administered by unit/department staff and by QA staff. As a result the process for inter-rater reliability was evident and results included in monthly data reports. For example, in the data prepared for the June QA/QI Council meeting it was reported that for Section C of the Settlement Agreement 44 monitoring tools were administered by Department staff and four by QA staff. More importantly, it was evident that inter-rater reliability data, when not congruent, was used to generate discussion among raters leading to improved auditing methodology and interpretation of acceptable practice.<br><br>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:<br>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. | |

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| | | 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.<br><br>In at least the last two reports, the Monitoring Team noted that QA activity at DSSLC consisted almost exclusively of work effort directed at the first of these two strategies. This continued to be the case. Activity directed at the second strategy was not evident. The Monitoring Team again 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 Facility-wide or 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.<br><br>The Facility did not address the analysis and use of data for decision-making or for the identification of systemic issues facing the Facility in its self-assessment. This is important information associated with this section of the SA, particularly with respect to Provision E.2.<br><br>The Monitoring Team concurs with the Facility self-assessment that this Provision was not in substantial compliance. | |
| E2 | Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur. | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Reviewed Quality Assurance plan for accuracy.<br>2. Reviewed corrective action plan tracking log.<br>3. Reviewed tracking and trending of data presented in the QAQI reports April – September 2012<br>4. Reviewed inter-rater reliability data.<br>5. Reviewed QAQI minutes for April 2012, May 2012, June 2012, July 2012, and August 2012 to ensure all discussions were included in the minutes.<br>6. Reviewed data analysis by Section Leads.<br>7. Reviewed data for reliability.<br><br>From its self-assessment the Facility determined that: | Noncompliance |

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| | | 1. QA Plan continues to be revised as changes are needed. The last changes being done on 9/14/12.<br>2. Of the 23 formal corrective action plans implemented and reflected on the Corrective Action Plan (CAP) tracking log, timely identification of completion was lacking, and evidence of completion not provided timely.<br>3. 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.<br>4. Inter-rater reliability data for Section V, and Section M, has been presented to QAQI. Reliability data for Section V is low. Section Leader for V will continue to do inter-rater reliability checks with the Records Clerks until the reliability scores are above 85%.<br>5. The QAQI minutes include what sections were discussed, corrective action plans submitted, and any required follow up action.<br>6. 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.<br>7. Identified 5 Staff that will complete competency based training and inter-rater reliability for the Engagement tool in order to collect accurate data.<br>Identified 7 Staff that will complete inter-rater reliability for Meal Monitoring in order to collect accurate data and to competently train Unit Staff. These 5 staff began their audits 6/1/12.<br><br>Based on the findings from this self-assessment, this provision is not in substantial compliance because data is not consistently reliable in all sections to drive systemic changes, and we are in the beginning stages of collecting reliable analysis of the data from the Section Leads. We are in the beginning stages of the follow-up of Corrective Action Plans to ensure there is evidence of completion.<br><br>Monitoring Team note: the conclusion reached in this self-assessment is virtually identical to that reached in the last self-assessment six months ago leaving the Monitoring Team to question the degree to which any significant progress had been achieved.<br><br><u>Monitoring Team Findings:</u><br>An important element of this Provision is using data to develop and implement Corrective Action Plans (CAPs) to address problems identified through the quality assurance process. The Facility produced a great deal of data which demonstrated its process for data collection, data assembly, report preparation, report presentation to the QA/QI Council, and a report format from which a Corrective Action Plan could be | |

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| | | prepared and submitted the QA Department. The Facility produced very little evidence that its administrative QA processes had matured to the point that routinely resulted in preparation of Corrective Action Plans correlating to the analysis of performance data. For example, the Presentation Book prepared for the Monitoring Team did not include any examples of CAPs to document compliance with Provision E.2.<br><br>To the degree CAPs were found and reviewed by the Monitoring Team they generally were overly specific targeting primarily issues with staff compliance identified through the use of the monitoring tools. They did not usually articulate a clear statement of the problem the CAP was going to address. For example, the CAP presented to the Monitoring Team as an example addressed separately several areas of noncompliance with restraint documentation. Each issue associated with documentation was identified as a unique issue when in fact the issue requiring a CAP was more likely "we need to improve the accuracy and timeliness of restraint documentation." For CAPs to be effective and have their effectiveness measurable they should be written and developed starting with a statement of the problem that a series of actions (and their corresponding outcomes) is designed to address. This observation by the Monitoring Team was made in the last review and little evidence of progress was presented to the Monitoring Team. The Presentation Book prepared by the Monitoring Team for Provision E.2 consisted almost exclusively of data reports generated since the last review with little evidence that it was analyzed and used in the development of substantive CAPs.<br><br>Most of the data reviewed by the QA/QI Council came from the monitoring tools that are used for each provision of the SA. The Monitoring Team was able to determine that there was some evidence that corrective action plans were initiated when monitoring discovered specific deficient practices. 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. This issue was also presented in the last report by the Monitoring Team.<br><br>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 evaluating progress in this regard at the next review.<br><br>In its last report the Monitoring Team noted that for the Facility to be in compliance with this provision, a system would need to be in place that identified many components of protections, supports, and services. With respect to the collection of data and generating reports to submit to the QA/QI Council the Facility had made progress. In addition to collecting and reviewing monitoring data, and making certain those data are reliable and | |

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| | | tracking corrective actions, the Facility would need to continue to refine its key indicators and outcome measures. The Facility needs to take the next big step in the QA process – using its extensive library of data to develop problem/issue statements and initiate substantive CAPs that, after implementation, can measure effectiveness in addressing the originally identified problem(s). As noted in the last report by the Monitoring Team, data analysis needs to be sufficiently robust to enable the Facility to proactively identify homes, day/vocational programs, and/or departments that require improvement, issues for whom the corrective solutions are inter-departmental in nature, as well as to identify potential systemic issues requiring attention.<br><br>Please refer to Provision E.1 for additional information that effects compliance with this Provision.<br><br>The work effort observed during this monitoring visit demonstrated continued improvement in the development and implementation of an effective QA system but there is considerably more that needs to be done.<br><br>The Monitoring Team concurs with the Facility self-assessment that this Provision was not in substantial compliance. | |
| E3 | Disseminate corrective action plans to all entities responsible for their implementation. | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Review CAPs tracking system to ensure all CAPs implemented within the past 6 months have been disseminated to all responsible parties.<br>2. Reviewed and updated Quality Assistance System Flow Sheet.<br>3. Reviewed requirements for corrective action plans to determine if revisions are needed.<br>4. Conducted observations at QAQI for dissemination of corrective action plans.<br><br>From its self-assessment the Facility determined that:<br>1. CAP database was revised to include a date of when the CAP was disseminated to responsible parties and who it was disseminated to.<br>2. The review of the Quality Assistance System Flow Sheet found that the Quality Assurance Department coordinates quality assurance activities with multiple departments.<br>3. Corrective action plans requirements have stayed the same. Corrective action plans are required when the data drops below the identified threshold of 85% and there has not been any improvement for 2 months.<br>4. QAQI minutes (June, July, and August) now reflect that completed Corrective Action Plans are disseminated during the meetings. Additionally, a Corrective | Noncompliance |

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| | | Action Plan can be requested at any time at the discretion of the QA/QI Council and will be disseminated to the responsible parties via email by the Quality Assurance Director.<br><br>Based on the findings from this self-assessment, this provision is not in substantial compliance because not all Corrective Action Plans could be verified that all entities responsible received the corrective action plans (CAPS) for implementation through QA/QI minutes.<br><br><u>Monitoring Team Findings:</u><br>The Facility relied primarily on its CAP Tracking System to validate that corrective action plans were disseminated to all entities responsible for their implementation. The system to accomplish this was not well defined or organized. There were 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." From its title it could be assumed the name appearing in this box would have something to do with implementation responsibility. 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.<br><br>Minutes of each QA/QI Council also noted CAP information but were inconsistent in reporting who a CAP was assigned to and respective due dates. A typical entry in QA/QI Council minutes was "A CAP will be written and turned in, assigned to D/J, due date 9/7/12" (excerpt from meeting minutes from 8/24/12). If the Facility chooses to have minutes of the QA/QI Council be a source of documentation for compliance with this Provision, it needs to be sure information is presented with clarity.<br><br>The Monitoring Team concurs with the Facility self-assessment that this Provision was not in substantial compliance. | |
| 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. | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Reviewed follow up needed on corrective action plan data base.<br>2. Conducted observations at QAQI for Corrective Action Plan implementation.<br>3. Reviewed requirements for corrective action plans.<br>4. Interviewed section leaders on knowledge of corrective action plans.<br><br>From its self-assessment the Facility determined that:<br>1. The corrective action plan database listed areas where follow up was needed but | Noncompliance |

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| | | 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<br>2. Observations during QAQI found that some completed Corrective Action Plans (June, July, and August meetings) are disseminated and plans are discussed during the meetings.<br>3. Corrective action plans are required when the data drops below the identified threshold of 85% and/or there has not been any improvement for 2 months.<br>4. Not all section leaders interviewed could state how they tracked whether or not a corrective action plan has met the desired outcome.<br>Self-rating:<br>Based on the findings from this self-assessment, this provision is not in substantial compliance because the corrective action plan data base could not identify whether or not a previously completed corrective action plan has met the desired outcome.<br><br>Monitoring Team note: the conclusion reached in this self-assessment is virtually identical to that reached in the last self-assessment six months ago leaving the Monitoring Team to question the degree to which any significant progress had been achieved.<br><br>Monitoring Team Findings:<br>In the last report the Monitoring Team noted that 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 that review six months ago, organization of CAP tracking data of this nature could not be done. Although the Facility can (and did) produce lists of open and closed CAPs, these were not further delineated by similar subject matter or department assignment, so they did not provide information that could easily lead to remedying or reducing the problems originally identified, as described in more detail in Provision E.2.<br><br>To achieve compliance, the Facility must demonstrate CAPs have been implemented, 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 that the CAP is revised if not effective.<br><br>The Monitoring Team concurs with the Facility self-assessment that this Provision was not in substantial compliance. | |

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| E5 | Modify corrective action plans, as necessary, to ensure their effectiveness. | Facility Self-Assessment:<br>The Facility engaged in the following activities in conducting its self-assessment of this Provision.<br>1. Reviewed follow up needed on corrective action plan data base.<br>2. Conducted observations at QAQI.<br>3. Reviewed evidence submitted for corrective action plans.<br><br>From its self-assessment the Facility determined that:<br>1. The corrective action plan database provided information when follow up was needed.<br>2. Observations during QAQI indicate not all members are familiar with the process of modifying corrective action plans.<br>3. Evidence was not submitted to the Quality Assurance Director if corrective action plans were modified.<br><br>Based on the findings from this self-assessment, this provision is 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.<br><br>Monitoring Team note: the conclusion reached in this self-assessment is virtually identical to that reached in the last self-assessment six months ago leaving the Monitoring Team to question the degree to which any significant progress had been achieved.<br><br>Monitoring Team Findings:<br>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.<br><br>The Monitoring Team concurs with the Facility self-assessment that this Provision was not in substantial compliance. 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. | Noncompliance |

| **Recommendations:** The following recommendations are offered for consideration by the State and the Facility: | **Recommenda** |
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| 1. Develop a system of "weighting" data items on monitoring tools, where appropriate. (Provision E.1)<br>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)<br>3. Develop a methodology to define and identify staff who should and do receive CAPs. (Provision E.3)<br>**4.** Organize information related to CAPs in such a way data can be used to help identify systemic issues. (Provision E.2)<br>5. Organize information related to CAPs so that effectiveness can be measured and CAPs can be modified as necessary. (Provision E.5) | |

| SECTION F: Integrated Protections, Services, Treatments, and Supports | |
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| 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:**<br>**Documents Reviewed:**<br>1. Denton State Supported Living Center (DSSLC) Self-Assessment, updated 09/24/12<br>2. Denton State Supported Living Center Action Plans, updated 09/24/12<br>3. Denton State Supported Living Center Report for Monitors, dated October 8, 2012<br>4. Section F Presentation Book materials<br>5. DADS Policy 018: Most Integrated Setting Practices, 3/30/10<br>6. Draft of updated DADS Policy 018: Most Integrated Setting, undated<br>7. Draft DADS Policy 017: Habilitation, Training, Education and Skill Acquisition Programs, effective 5/10/12<br>8. Compliance per Individual-Annual Assessments, dated Tuesday, September 04, 2012<br>9. PSP Dates by Individuals, dated Tuesday, September 04, 2012<br>10. PSP Attendance–All Meeting Types 4/1/2012-8/31-2012, dated Tuesday, September 04, 2012<br>11. ISP assessments for Individuals #250 and #750<br>12. ISP assessments reviewed for timeliness for Individuals #52, #86, #210, #244, #250, #412, #746, and #750; ISP Assessment in shared drive for Individual #578<br>13. Memory Book for Individual #345<br>14. Monthly and Quarterly Reviews for Individuals #191, #250, #350, #381, and #750<br>15. Individual Support Plans (ISPs) and Preferences and Strengths Inventory (PSI) for Individuals #56, #61, #101, #211, #232, #250, #352, #371, #627, #741, and #750<br>16. Completed ISP Monitoring Tool for Individual #639<br>**People Interviewed:**<br>1. Clark Clermont, Director of Community and Family Relations (CFR)<br>2. Leslie Clark, QDDP Coordinator<br>3. Frank Padia, QDDP Facilitator<br>4. Lori Powell, Director of Quality Assurance<br>**Meeting Attended/Observations:**<br>1. ISP annual planning meetings for Individuals #250 and #750 |
| | **Facility Self-Assessment:**<br>The Monitoring Team reviewed the DSSLC Self-Assessment and accompanying Action Plans. DSSLC reported it was not in compliance with any of the provisions of this section of the SA. The Monitoring Team concurred. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. In its Self-Assessment for Section F, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment, and 3) a self-rating.<br><br>For Section F, in conducting its self-assessment, the Facility had in some instances coupled the self- |

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| | assessment with its internal quality assurance processes to assess ongoing progress toward actual outcomes, in that it reviewed the results of internal Section F Monitoring Tools as a part of its self-assessment processes. It was noted by the Monitoring Team that there was a newly created and implemented monitoring tool, the ISP Monitoring Tool, which had begun to be used to evaluate the ISP and to measure the outcomes. No data from the tools was yet referenced as it was a very new process. The ISP monitoring tool represented an overall improvement in the Facility's processes for ISP review, but still had certain deficiencies in terms of measuring outcomes. The tool:<br>• Did not always include adequate indicators and/or methodologies to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations.<br>• Did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. Many of the questions asked whether the IDT discussed an issue, but there were no criteria for what an adequate discussion should entail.<br>• There was no process described to ensure the staff responsible for conducting the audits/monitoring, QA staff and the QDDP Coordinator, had been deemed competent in the use of the tools. The Facility acknowledged that adequate inter-rater reliability had not yet been established between the Facility staff responsible for the completion of the tools.<br><br>The Monitoring Team also reviewed the Action Plans. Overall, many of the Action Plans were thoughtful and included a set of steps likely to lead to compliance with the requirements of this Section if fully implemented. There did need to be a clearer plan for measuring the outcomes of each of these and include this in the Evidence column in addition to the paper compliance evidence found there. In some cases, Action steps were designated as completed, but evidence found during this monitoring visit would suggest the desired outcomes had not been achieved. For example, it was reported that QDDPs had completed training on monthlies and quarterlies, but both this review and the Facility's own self-assessment data indicated this remained a problem area. The Facility should update its Action Plans for improvement when outcomes have not yet been achieved. |
| | **Summary of Monitor's Assessment:**<br>This Section was found to be not in compliance. A summary of progress includes: The Facility continued to devote considerable resources to training, monitoring, and coaching for QDDPs, an effort the Monitoring Team commends. The Facility had added a Facilitator Coordinator position, whose job description indicated he was responsible for ensuring all QDDPs become competent in facilitating meetings. In addition, the Facility had offered a QDDP Skills Fair, brought in an external resource to provide training on development of Skill Acquisition Plans (SAPs), and offered competency-based training on completing the Rights Assessment. The Monitoring Team was particularly pleased to observe the Facility's focus on enhancing the timeliness and quality of assessments and its thoughtful approach in developing new and revised quality assurance measures that identify and remediate problems to ensure that the ISPs are developed and implemented. There was evidence that at least the timeliness of assessments had improved substantially. The Monitoring Team commends the Facility for its initiative in this area and looks forward to reviewing the process as it matures. |

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| | **Provision F1:** This provision was found to be not in compliance. The ISP process was still meeting with limited success specific to the requirements of this Section. 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. A somewhat revised ISP format and process had been recently introduced; while the Monitoring Team reviewed a number of recent ISPs, much of its focus throughout this section was on the two new format ISPs. Overall, the Monitoring Team found the quality of facilitation continued to improve, but the new process was cumbersome and somewhat disjointed and made meaningful individual participation by the individual even less likely.<br><br>**Provision F2:** This provision was found to be not in compliance. Overall, ISPs lacked many of the criteria specified in the SA for this Provision. A full review was hampered by a failure of the Facility to provide adequate data, so the Monitoring Team was unable to fully evaluate the extent to which the ISP provide interventions, strategies, and supports that effectively addressed the individual's needs for services and supports and were practical and functional at the Facility and in community settings. The Facility had made some improvements in ensuring an assessment of progress on a monthly basis, or more frequently as needed, or make revisions if there was a lack of expected progress. Overall, however, 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. The Facility did not consistently ensure that programs or services prescribed in the ISP were modified as needed. Monthly/Quarterly reviews also indicated that individuals' ISPs were not consistently put into effect within 30 days of preparations. |

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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 29 QDDP positions, with two current vacancies. Eleven of the QDDPs had been hired within the last six months. In addition, a new QDDP Coordinator was hired in June 2012. The previous QDDP Coordinator took a newly created position as Facilitator Coordinator. The Facility also had a QDDP Educator. The Facility continued to devote considerable resources to training, monitoring, and coaching for QDDPs, both new and current, an effort the Monitoring Team commends. This training included ongoing Q Construction facilitation training. Based on the list provided, the Facility had seven staff who had been deemed competent in facilitation. Additional training initiatives are described in more | Noncompliance |

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| | | detail in Provision F2e below. The Facilitator Coordinator job description indicated he was responsible for ensuring all QDDPs become competent in facilitating meetings.<br><br>Overall, in the two new format ISPs observed, the Monitoring Team found the quality of facilitation was continuing to improve. These two meetings were facilitated by the QDDP Educator and the Facilitator Coordinator. In one of meetings observed while the Monitoring Team was onsite, the facilitator shared much of the leadership of the meeting with the LAR, who played a significant role in raising topics and ensuring certain items were discussed. In both meetings, the facilitator worked diligently to focus the IDT's attention and to stay on task. In one instance, however, the Monitoring Team found the facilitator still had an awkward approach to discussing the most integrated setting. See Provision F1e for more detail.<br><br>The assigned QDDP also remained responsible for monitoring and revising 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.<br><br><u>Conclusion:</u> 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. | <u>Composition and Participation of IDT:</u><br>The Facility was unable to produce reliable summary data relative to ISP planning meeting attendance. Material provided to the Monitoring Team did not display (as requested), by Individual, which disciplines and other staff were required to attend the ISP planning meeting and whether or not they did. The Facility must produce data of this sort, not only to provide evidence of compliance but, more important, to be able to identify improvements needed and take action. The Facility had no organized method to track compliance and no managerial oversight process from which problem areas could be identified and corrective action plans could be developed. ISP attendance was not addressed in the Facility's self-assessment. The Monitoring Team reviewed the signature sheets for all eight ISPs held during the week of the site visit. Examples of attendance noted:<br>• Seven included the individual;<br>• Five included a Direct Support Professional;<br>• Eight included the QDDP;<br>• Five included a family member/LAR or advocate;<br>• Eight included the Registered Nurse;<br>• Five included Psychologist or BCBA;<br>• Four included Active Treatment staff;<br>• Eight included the Primary Care Physician. | Noncompliance |

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| | | Extent of Individual participation in ISP:<br>Meaningful participation by individuals themselves remained very limited, as reported in previous assessments by the Monitoring Team. Individuals with intellectual disabilities benefit from repeated and ongoing experiential activities in this area, as with many others, as opposed to once or twice a year. The State and Facility should consider how it might expand on the PSI process to be an ongoing process that truly supports individuals to be active participants in their own planning. A newly revised Preferences and Strengths Inventory (PSI) process, as described in DADS Policy 004: Individual Support Plan Process, was not robust enough to facilitate an individual's real understanding and participation. 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.<br><br>Such a planning process might include, for instance, many opportunities across the year for staff to assist each individual to create pictorial representations of the things that matter to them. Using photographs, drawings, pictures from magazines and books, for example, each individual could develop a poster portfolio of such things as "Important People in My Life," Things I Want to Do," Places I Want to Go," What My Ideal Home Looks Like," "Things I am Good At," etc. These posters could then be placed on the walls to begin the PSI 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 PSI areas with the individual. The portfolio could then be revised for the ISP meeting based on the PSI results. This would make the ISP a much more comprehensible, participatory and positive experience. It was noted the Facility had begun some attempt to implement this recommendation. The Director of CFR provided for review an example of a Memory Book, a personal portfolio for one individual. It included many pictures of things the individual liked or enjoyed doing and had been worked on over a period of time. This was the only such book that had been developed thus far, but the Facility reported it planned to work with additional individuals to create more of these.<br><br>During this site visit, the Monitoring Team observed two ISPs in the newly revised format and process. While the Monitoring Team appreciated the intent of completing the Integrated Risk Rating Form (IRRF) at the beginning of the meeting, it found this was detrimental to the participation of the individual. Both meetings began with a very brief review of an individual's preferences from the PSI. This was followed by the IRRF discussion, which in both cases consumed the next two hours. This discussion was not held in such a way as to be meaningful or comprehensible to the individual. In addition, a | |

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| | | two hour discussion focused on risks and problems did not set a stage for developing a plan based on an individual's personal goals, preferences and strengths. The Monitoring Team recommends the State and Facility reconsider how the process can be modified to better support such a plan.<br><br><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>Status of Policy and Procedures</u>:<br>DADS Draft Policy #004 defined "assessment" as "A formal document that identifies an individual's current level of functioning, preferences, strengths, needs, and recommendations to achieve his or her goals, promote independence, and overcome obstacles to community integration. The assessment is used to identify strengths and needs to support the individual in the development of training, participation, and service objectives listed in the "Action Plans" section of the ISP." In Section II.E, the policy stated: "IDT members prepare for the ISP meeting by:<br>• Completing the recommended and required assessments and placing them on the facility computer shared drive for the IDT to review no later than five (5) working days prior to the initial ISP meeting; and<br>• Reviewing all assessments for the initial ISP to be prepared for a comprehensive, integrated discussion during the ISP meeting."<br><br>For annual ISP planning meetings, this policy requires in Section III.C that assessments be completed and placed in the share drive for IDT review no later than 10 working days before the annual ISP meeting. Facility policy required assessments to be in the shared drive no later than ten days prior to the annual ISP planning meeting.<br><br><u>Extent to which assessments are conducted routinely:</u><br>As described in previous reports by the Monitoring Team the Facility has had a difficult time complying with the policy requirements associated with the timeliness and quality of clinical and other assessments necessary to prepare for an individual's annual ISP meeting. The Facility had taken some action to address this significant problem and reported two new initiatives to address this chronic problem.<br>• <u>Timeliness of assessments</u><br>The Facility had recently initiated a management oversight process operating from the QA Department. The database developed to support this process identified assessments due by date by Individual. This generated a "reminder" to the appropriate discipline coordinator. A similar identification and reminder occurred if the assessment was not completed on time. The Facility had begun to take administrative action with specific staff that remained noncompliant with policy requirements for timely assessments. The preliminary results of this new | Noncompliance |

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| | | process were encouraging. In all assessment areas the percentage of compliance increased from August to September. For example, the timeliness of medical assessments increased from 50% compliant to 90% compliant. The timeliness of vocational assessment increased from 55% compliant to 90% compliant.<br><br>The Monitoring Team reviewed the timeliness of assessments for eight ISPs held during the week of the monitoring visit and found most assessments were completed on a timely basis. The only consistent exception was the psychiatry assessments; when present, they were consistently completed only a day or two before the ISP. It was also noted that communications assessments were sometimes very dated, including two that were more than ten years old. Finally, a review of assessments available for an upcoming ISP due within the next ten days demonstrated a high level of timeliness overall for those assessments that were present. The Facility was not yet able to evaluate whether all needed assessments were present as it did not have an individualized list of required documents. Therefore, this was not assessed. It is anticipated that the new ISP process, which requires the IDT to hold a pre-ISP meeting in which the assessment requirements will be specified, will make this evaluation possible. The Monitoring Team commends the Facility for its significant progress in this area overall and looks forward to seeing continued improvement in its next review.<br><br><u>Extent to which to which assessments are conducted in response to significant changes:</u><br>The Monitoring Team found that there were some instances in which assessments were being updated in response to significant changes. For example,<br>• As reported in Provision M1, the quality and comprehensiveness of the nursing assessments and documentation for individuals with acute changes in status related to specific affected body systems had continued to improve since the last compliance visit.<br>• As reported in Section L, physicians have begun the process of evaluating chronic medical conditions on a quarterly basis.<br><br>There were still instances in which in which assessments were not being conducted or updated in response to significant changes. For example:<br>• As reported in Section O, a review of eight individuals diagnosed with pneumonia and/or choking indicated eight of eight (100%) were discussed at the PNMT or Interdisciplinary Team (IDT) meeting, but a concern by the Monitoring Team was that all individuals who were in need of a comprehensive PNMT evaluation were not consistently provided with one. Out of the 6 individuals who were diagnosed with pneumonia, only two (33%) were | |

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| | | provided with a comprehensive assessment by the PNMT.<br><br>Extent to which to which assessments are of sufficient quality to reliably identify the individual's strengths, preferences and needs:<br>The Facility had recently initiated a quality assurance process it called "assessment of the assessments." This was primarily a system of peer review usually conducted by discipline coordinators. The early results were encouraging. Both the Behavioral Services and the Physical/Occupational Therapy departments reported a noticeable improvement in assessments as a result of the staff learning that occurred during the "assessment of the assessments" process. Also as reported in Section L, the Monitoring Team found annual physician assessments were more comprehensive, included all known medical conditions, and included a more comprehensive action plan for each known medical condition. The current medical problem list was more complete, compared to previous reviews.<br><br>Overall, assessments were not yet routinely of sufficient quality to reliably identify the individual's strengths, preferences and needs. Examples included:<br>• As reported in Provision K6, minimal documentation in the record, reflected that intellectual, adaptive behavior, or mental illness assessments were current, accurate, or complete.<br>• As reported in Provision R2, based on review of 31 assessments (Samples #1, #2, #3, #4 and #5), 14 of 31 (45%) individuals had comprehensive assessments that contained each of the required elements. Those assessments that were not considered to be comprehensive did not include the manner in which strategies, interventions, and programs should be utilized throughout the day or Factors for Community Placement.<br>• As reported in Provisions T1c1 and L1, assessments did not reliably identify the scope of an individual's health care needs and/or the supports required for these needs in a community setting, resulting in an inadequate Community Living Discharge Plan (CLDP).<br>• As reported in Provision S1, DSSLC was asked to provide an example from each of the seven homes that reflected the best work in developing Skill Acquisition Plans (SAPs) through the ISP process. This example was to include the ISP, the Functional and Structural Assessment (FSA), and assessments from other disciplines and clinicians. None of the five examples (0%) included all relevant assessments associated with the ISP process. Without the requested assessments and other documentation, it was not possible to determine whether individuals were provided with the necessary annual assessments or whether these were completed in such a manner as to reliably identify the individual's strengths, preferences and needs. | |

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| | | Conclusion: This provision was found to be not in compliance. The Monitoring Team looks forward to seeing continued improvement in its next review. | |
| 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. | Extent to which assessment results are used to develop ISPs:<br>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 were not 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 as described further in Provision F2a.<br><br>Conclusion: This provision was found to be not in compliance. | Noncompliance |
| F1e | Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999). | This provision is discussed in detail later in this report with respect to the Facility's progress in implementing the provisions included in Section T of the Settlement Agreement. The Monitoring Team attended one full ISP annual planning meeting and reviewed 10 recent ISPs as measures of how this process may have affected the IDTs' implementation of this requirement of the SA. The IDT was expected to indicate the most integrated setting appropriate to an individual's and, if they chose not to make a referral, indicate the reason(s) for that choice. The new ISP format had been re-designed to force this determination, and the Monitoring Team found recent ISPs were more likely to provide it. Overall, however, the Monitoring Team found the IDTs still failed to fully understand their roles and responsibilities in making a professional determination as to the most integrated setting appropriate to an individual's needs.<br><br>In order for the State Office requirement to be met, each discipline's assessment needed to include an opinion/recommendation. In addition, at the ISP meeting, the team needed to make a recommendation to the individual/guardian. The Monitoring Team focused its attention in this area on the two new-format ISPs and found the following:<br>• In neither (0%) did all of the assessments include the applicable statement/recommendation. Failure to address the most integrated setting occurred most commonly in the Functional Skills Assessment and the Pharmacy assessment.<br>• In most cases, the assessments did include a statement that the individual's needs for supports and services could be met in a community setting. These often took the form of a canned template statement that was not individualized. Only rarely was the statement accompanied by any statements regarding | Noncompliance |

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| | | services and supports specific to needs in a community setting.<br>• In most cases, the template statement indicated that the professional opinion was based on the current services and support being provided at the Facility and did not take into account that any different services might be needed in the community.<br><br>In Provision T.1.b.1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such obstacles. In summary, the Facility was not yet effectively identifying or addressing obstacles. For example, zero of nine (0%) of the ISPs reviewed in which a referral was not made evidenced proficiency in identification and addressing of obstacles. In none of the five (0%) that identified LAR or individual choice as the barrier were there specific action plans developed to address the barriers.<br><br>The Facility had provided some additional training for teams related to the most integrated setting requirements and/or Olmstead decision. The Monitoring Team observed in its review of ISP documents and in attendance at one on-site new format meeting that QDDPs and IDTs did not yet appear to be comfortable in addressing the concept and spirit of the most integrated setting as defined in the ADA and Olmstead. Examples included:<br>• For Individual #250, the guardian was known to be opposed to community living due to a history of bad experiences in such settings. When the living options portion of the meeting was reached, the Facilitator began the process by commenting on a move across campus a couple of years before that had been a "disaster" and asked whether that could be considered an indicator of his preference. While it was known the guardian was opposed to community living, this opening did not set a stage for any positive discussion of the possibilities at all.<br>• For Individual #627, the ISP documented that the QDDP told the individual's sister that without an LAR the team "has to" make a placement recommendation based on the individual's desires and team professional opinions.<br>• For Individual #61, according to review of the ISP, the QDDP told the individual's sister that "(u)nfortunately, at this time since there are no barriers to (the individual) moving to the community, (the) team by law has to schedule" community tours. She also told the sister if she established guardianship, touring community options could be discontinued.<br><br>The Monitoring Team encourages the Facility to continue to provide ongoing training to the IDTs in the philosophy of providing individuals with the opportunity to live in the most integrated setting so that they might more effectively and comfortably convey same | |

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| | | to family members and LARs.<br><br>Conclusion: 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: | | |
| 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; | This provision of the Settlement Agreement addresses a number of specific requirements, including identification and use of individuals' preferences and strengths, prioritization of needs and explanation for any need or barrier not addressed, and identification of supports needed to encourage community integration. Each of these is addressed separately below.<br><br>Status of Policies and Procedures:<br>DADS Draft Policy #004.1 at II.F.4 indicated that action plans should be based on the individual's preferences, strengths, and needs. The policy further indicated: "The IDT must have a comprehensive, integrated discussion with input from each team member on how he or she will formally or informally support the prioritized action plans." The revised policy included considerable detail regarding the types of action plans teams should develop (i.e., skill acquisition plans, participation objectives, service objectives, and specific objectives to address individual risk factors); the content of action plans; topics that action plans should cover. It also required teams to "consider every opportunity for community integration," as well as ensure that "Outcomes and objectives are expressed in terms that provide measurable indices of performance…"<br><br>The Facility had very recently begun to implement another revision to the ISP process, which had been incorporated into draft DADS Policy 004: Individual Support Plan Process. Training had been provided to QDDPs on the use of this updated format. 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 | Noncompliance |

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| | | 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.<br><br><u>Extent to which ISP builds on the individual's preferences and strengths and prioritized needs:</u><br>IDTs did not consistently address in the ISP each individual's prioritized needs. The following concerns were also noted with regard to the identification and incorporation of preferences and strengths into ISPs:<br>• Little, if any, information about individuals' specific strengths was discussed in eleven recent ISP documents. Strengths were not regularly built upon to address other need areas. This was true for all of those reviewed regardless of whether the "updated" format was used.<br>• The revised PSI process had had no substantial positive impact on the extent to which the IDTs documented preferences or analyzed how they might be used to develop an optimistic living vision for an individual.<br><br><u>Extent to which ISP provides an explanation for any need or barrier that is not addressed:</u><br>IDTs did not consistently provide an explanation for any need or barrier that was not addressed. In none of the eleven (0%) ISPs reviewed/attended for Section F were priorities clearly defined and addressed, nor barriers identified and addressed.<br><br><u>Extent to which ISP encourages community participation:</u><br>IDTs did not consistently encourage community participation. As reported in Provision S3b, data presented by DSSLC reflected a decrease in the provision of community outings since the previous monitoring visit. There was reported to be an increased emphasis on skill acquisition action plans for implementation in the community rather than on the number of outings, but this could not be substantiated by the Monitoring Team. The data presented for Section S was not sufficient to allow for an evaluation. Of the eleven recent ISPs reviewed specifically for Section F, including the two new examples, none (0%) reviewed included specific skill acquisition action plans for implementation in the community and only a few included at least one measurable objective for general community participation. | |

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| | | As recommended in Provision T1b2, the Facility's IDTs should develop an individualized community participation 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.<br><br>Conclusion: 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; | 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:<br>As described in Section S, the Monitoring Team was unable to evaluate, due to a failure of the Facility to provide adequate documentation, whether ISP programs were generally individualized to the individual's needs, and if they contained the requisite essential components of skill acquisition programs such as operational definitions of teaching targets, discriminative stimuli, consequences, and teaching instructions.<br><br>In the section below that addresses Provision T1b1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. This also requires the development of action plans in ISPs. In summary, the Monitoring Team found that obstacles to transition were not yet appropriately identified or addressed by the IDTs. In a review of 10 recent ISPs, including the two new ISPs, two resulted in a referral. Zero of eight (0%) of the ISPs reviewed in which a referral was not made evidenced proficiency in identification and addressing of obstacles. In many cases, the IDTs identified issues or resources that would be available in the community, indicating additional education for IDT members is required.<br><br>Conclusion: This provision was found to be not in compliance. | Noncompliance |
| | 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:<br>ISPs still failed overall to consistently integrate all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for an individual. Examples included:<br>• As reported in Section J, the integration of mental health issues into the | Noncompliance |

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| | | functional assessment, although much improved, did not consistently meet expectations.<br>• As reported in Provision L1, the Monitoring Team had serious concern over the lack of comprehensive plans and integration of services to address the support needs for several important medical conditions.<br>• As reported in Provision K5, the integration of mental health issues into the functional assessment, although much improved, did not consistently meet expectations.<br>• As reported in Provision R3, zero of 25 (0%) ISPs included how the communication interventions were to be integrated into the individual's daily routine.<br><br><u>Conclusion:</u> This provision was found not to be in compliance. | |
| | 4. Identifies the methods for implementation, time frames for completion, and the staff responsible; | <u>Extent to which ISP identifies the methods for implementation, time frames for completion, and the staff responsible</u>:<br>The ISP did not consistently identify the methods for implementation, time frames for completion, and the staff responsible for all interventions. Examples included:<br>• As reported in Provision S1, DSSLC was asked to provide an example from each of the seven homes that reflected the best work in developing SAPs through the ISP process. This example was to include the ISP, the Functional Skills Assessment (FSA), assessments from other disciplines and clinicians, SAPs, data collection forms for the SAPs, data graphs, and SAP progress notes. Although the Facility did provide example material from each of the five units, for none of the units was the material complete. Of the material that was presented by the Facility, only one example (20%) included all SAPs and monthly SAP data sheets. None of the seven examples (0%) included all relevant assessments associated with the ISP process. Although some examples included progress notes and graphs, these progress notes lacked dates, narratives, and indications of which SAP was the focus of the note or graph. Without the requested assessments and other documentation, it was not possible to complete a review of the use of assessments in the development of SAPs. Furthermore, the lack of SAPs and data forms prevents a review of the quality of SAP content.<br>• As reported in Provision K9, PBSPs that were based upon those functional assessments lacked clearly identified replacement behaviors and often did not include the necessary teaching strategies.<br>• As reported in Provision T1b2, for none of ten (0%) recently completed ISPs was there an individualized plan for implementing awareness of community living options that took into account the learning needs of the individual. | Noncompliance |

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| | | Conclusion: This provision was found to be not in compliance. | |
| | 5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and | Extent to which ISP interventions, strategies, and supports are provided as prescribed:<br>The Monitoring Team found a number of instances that the interventions, strategies, and supports were not provided as prescribed in the ISP. Monthly and quarterly reviews demonstrated the failure of the Facility to routinely implement these services and supports. These are further described in Provisions F2d and F2f.<br><br>Extent to which interventions, strategies, and supports are practical and functional:<br>As reported in Section S, due to a failure to provide adequate data, the Monitoring Team was unable to fully evaluate the extent to which the ISP provide interventions, strategies, and supports that effectively addressed the individual's needs for services and supports and were practical and functional at the Facility and in community settings. In the absence of the ability to evaluate the Skill Acquisition Programs (SAPs) overall, there was evidence found that the Facility was not yet providing adequate interventions in other areas such as the PNMP. Examples included:<br>• As reported in Provision O3, based on a review of 18 individual PNMPs (sample #1, #2, and #3), individuals were not provided with a comprehensive PNMP.<br>o In ten of 18 PNMPs reviewed (55%), comprehensive strategies for oral hygiene were included.<br>o In five of 18 PNMPs (27%) reviewed, comprehensive strategies for medication administration were included. While this component has shown much improvement, the detail regarding safety or tolerance of pill intake was missing from the PNMP.<br>• 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:<br>o In eight of 19 (42%) observations, staff were following mealtime plans.<br>o In 11 of 23 (47%) observations staff were following positioning instructions.<br><br>Conclusion: This provision was found to be not in compliance. | Noncompliance |
| | 6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the | 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:<br>The ISP did not consistently identify the specific data and/or documentation and frequency of data collection that would permit the objective analysis of an individual's progress. Examples included:<br>• As reported in Provision K9, six of 18 (33%) PBSPs did not include specific instructions about how to collect data. In these PBSPs, instructions consisted | Noncompliance |

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| | individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review. | only of general statements about how to record the behavior or what form to use to collect data.<br>• One of two new format ISPs held during the monitoring visit did not consistently identify the data and/or documentation and frequency of data collection that would permit the objective analysis of an individual's progress. For Individual #250, almost every Service Objective and Training Objective indicated data documentation was to be completed "monthly," and almost all completion dates were listed as "ongoing." It was noted that the two ISPs used somewhat different formats for the Action Plans. The Facility should determine if it has an expectation that a single format is intended or whether it is permissible to use various templates.<br><br><u>Extent to which ISP identifies the person(s) responsible for the data collection, and the person(s) responsible for the data review:</u><br>The new format ISPs typically indicated by position who would be responsible for data review. The Action Plan template for one of two had a column that indicated which staff, by position, would be responsible for implementation, while the other had a similar column with the header "Persons Responsible for Implementation/Documentation.' While it is assumed the intent is the same, the expectation for documentation and data collection should be explicitly stated.<br><br><u>Conclusion:</u> This provision was found to be not in compliance. | |
| 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. | Based on the current review of ISPs, this was an area that required substantial improvement. As is discussed in other sections of this report, the Monitoring Team found a lack of coordinated supports in a number of areas, including between dental/medical and behavior/psychology; nursing and habilitation therapies; nursing and medical; speech/communication and psychology; and between the disciplines responsible for the provision of physical and nutritional supports to individuals served. Review of the ISPs generally showed a multidisciplinary as opposed to interdisciplinary approach, in that various disciplines might address the same issues, but rarely in a manner that caused them to pool efforts or resources in a coordinated approach to the same issue, or to consider how the actions of one discipline may hamper or augment the actions of another. Such considerations are the hallmarks of a truly interdisciplinary approach.<br><br><u>Conclusion:</u> This provision was found to be not in compliance. | Noncompliance |
| F2c | Commencing within six months of the Effective Date hereof and with full implementation within two | <u>Extent to which ISP is accessible to staff:</u><br>Although the Monitoring Team found staff were not consistently able to describe the contents of the ISP or programs without referring to the documents, they were able to | Noncompliance |

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| | years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it. | locate the information with relative ease when asked in most instances. As reported in Provision O4, 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. Based on interviews with eight DCPs, 100% were able to state where the PNMP/Dining Plan was located, but only 50% were able to state where the Aspiration Trigger Data Sheet was kept or when to document in it. It was also noted that, although the PNMPs were provided at various locations, at no time during any of the observations was staff observed referring to the PNMPs.<br><br><u>Extent to which ISP is comprehensible to staff:</u><br>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. In addition to data collection issues described in Provision F2a6 above, examples included:<br>• As reported in Provision K11, observations conducted during the site visit reflected that staff were not able to effectively provide behavior interventions.<br>• As reported in Provision O3, 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:<br>o In eight of 19 (42%) observations, staff were following mealtime plans.<br>o In 11 of 23 (47%) observations staff were following positioning instructions<br>▪ As reported on Provision O4, staff did not consistently understand rationale of recommendations and interventions as evidenced by not verbalizing reasons for strategies outlined in the PNMP. While staff knowledge had been maintained or improved by 10% or greater in all categories, the overall lack of knowledge resulted 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. Lack of understanding regarding why an intervention was important contributes to a lack of urgency regarding implementation. Based on interviews with eight DCPs, accurate responses to questions about PNMPs ranged from 25%-100%:<br>o What kind of transfer do they require? (100%)<br>o What do you look for to ensure the individual is in the correct position? (50%)<br>o Why does the individual need thickened liquids? (62%)<br>o Why does individual eat modified texture foods? (75%)<br>o Why does the individual require a specific utensil? (50%) | |

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| | | o Why does the individual require a specific assistance technique? (25%)<br>o What are the individual's risk indicators? What do you look for before, during and after the meal? (50%)<br>o Have you been trained to implement this plan? (75%)<br>• Who do you contact if you have difficulty with the plan or the equipment? (90%)<br><br><u>Conclusion:</u> 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, 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. | <u>Monthly review of progress</u>:<br>The Facility had made some improvements in ensuring an assessment of progress on a monthly basis, or more frequently as needed, or making revisions if there was a lack of expected progress. Examples included:<br>• As reported in Provision K4, 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, the Facility was much better prepared to provide an adequate review of behavioral and psychiatric interventions.<br>• As reported in Provision K5, based upon a review of the 18 functional assessments, it was evident that considerable improvement had been achieved and maintained by DSSLC. The latest format for functional assessments 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.<br><br>In many cases, however, IDTs did not consistently ensure assessment of progress on a monthly basis, or more frequently as needed, or make revisions if there was a lack of expected progress. Examples included:<br>• The Monitoring Team found that Monthly/Quarterly Reviews were often not completed in a timely fashion or in a way that provided for meaningful evaluation of progress or program revision. They provided little evaluative analysis; instead, they made general reports such as "service provided" or "no data provided." Monthly/Quarterly reviews for one of five individuals (20%) reviewed by the Monitoring Team provided any substantive evaluative analysis. | Noncompliance |

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| | | • As reported in Provision O7, per review of the monitoring list provided by DSSLC, 361 individuals had been provided with PNM monitoring. Out of the 361 monitoring forms completed, there was much missing data, indicating that significant PNM-related supports were not routinely assessed for efficacy of the related interventions. The monitoring for nutrition-related care focused primarily on mealtimes and/or snacks and medication administration but involved little focus on oral care; also, there was little focus on positioning related to communication. The percentages of monitoring for PNM related interventions were as follows (with some rounding error accounting for less than 100%):<br>o 4 of 361 (1%) focused on bathing<br>o 30 of 361 (8%) focused on communication<br>o 14 of 361 (4%)focused on lifting and transfers<br>o 109 of 361 (30%) focused on mealtime and/or snacks<br>o 74 of 361 (20%) focused on medication administration<br>o 9 of 361 (2%) focused on oral care<br>o 121 of 361 (34%) focused on positioning<br>• Also as reported in Provision O7, Issues noted with the Aspiration Trigger data sheet and process compromised effective data collection for review. These included:<br>o Lack of individualized triggers.<br>o Lack of consistent and detailed documentation surrounding the occurrence of triggers (e.g., activity in which trigger occurred, positioning of the individual).<br>o Lack of consistent completion by staff (missing data points).<br>o Lack of review by the appropriate nursing personnel<br><br><u>Extent to which ISPs are modified as appropriate:</u><br>The Facility did not ensure that programs or services prescribed in the ISP were modified as needed. Monthly/Quarterly reviews for five individuals reviewed by the Monitoring Team indicated for none of the five was the ISP consistently modified according to status change, progress or no progress. Examples included:<br>• In a number of cases, QDDPs reported progress data in a way that was vague or did not comport with the success criteria established. For example, Individual #250 was working on pedestrian skills and was to point to a red light upon request for 11 of 12 trials, but three monthly reviews stated only that he was showing progress with verbal prompts. No specific data were provided that would allow for an accurate evaluation of progress.<br>• For Individual #250, there was an Action Plan to visit a fire station, based on personal preferences, but the only notation for seven months was that the visit | |

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| | | had not been scheduled. This was particularly troublesome as the IDT continued, in the new ISP held during the week of the monitoring visit, to list quarterly visits to the fire station as something the individual consistently enjoys,.<br><br>Conclusion: 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 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. | Extent and adequacy of competency-based training for staff responsible for development of ISPs:<br>As reported 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. Since the last review, additional training sessions and resources had been initiated. These included:<br>• The Facility had hired a QDDP Facilitator to augment the work of the QDDP Educator to assist with training and competency-testing.<br>• The Facility held a Skills Fair for QDDPs in April 2012 focusing on areas such as Monthly Reviews, SAP development and completing the Functional Skills Assessment.<br>• There was an additional training on the Integrated Risk Form in August 2012.<br>• As reported in Section U, staff had been provided with competency-based training on the use of the expanded Rights Assessment. While this process was not sufficient to adequately assess an individual's need for assistance in decision-making, it did represent a step forward.<br>• As reported in Provision K12, competency-based training was being conducted with DSP (Direct Support Professional) staff by the Behavior Analysis Research Clinic (BARC) staff from the University of North Texas. The training program had three primary elements, 1) instruction on three informal behavior intervention procedures, 2) instruction on procedures for data collection, and 3) training on specific PBSPs. Training data provided by BARC reflected that DSP staff consistently improved skills related to all three elements of the training. In addition, interviews and observations with six DSP staff involved in the training that occurred during the site visit reflected not only improved skills, but also greater confidence and enthusiasm for their jobs.<br><br>Observations of two new-format ISPs indicated additional training continued 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, | Noncompliance |

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| | | priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs.<br><br><u>Extent and adequacy of competency-based training for staff responsible for implementation of ISPs:</u><br>The Facility reported there were no new policies or documents that addressed competency-based training on the implementation of individual's plans for staff responsible for the implementation of ISPs. There was some evidence of progress in some areas toward providing adequate competency-based training for staff responsible for implementation of ISPs. Examples reported throughout this report included:<br>• As reported in Provision O5, staff were provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff during new employee orientation. As of this review, percentage of staff trained on basic PNM related issues included:<br>o Lifting People (98%)<br>o Physical Management (100%)<br>o Preventing Aspiration Pneumonia (97%)<br>o Personal Care Services (99%)<br><br>Despite these improvements, the Monitoring Team found staff were still not adequately provided with competency-based training overall. This finding was made by the lack of active treatment and engagement observed, a lack of documentation of training completed 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. In addition to examples of these factors cited in Provision F2c, examples included:<br>• 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. The PNMC was working on a process to address this concern but at the time of the review a process had not been implemented.<br><br><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 | <u>Extent to which ISPs are developed within 30 days of admission:</u><br>DSSLC reported two admissions in the last six months. One was a recent admission and 30 days had not yet elapsed. For the second individual, according to the data provided, the 30-day ISP meeting was completed within 30 days as required. | Noncompliance |

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| | thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension. | Extent to which ISPs are revised annually and as needed:<br>The Facility provided the Monitoring Team with a list showing, for each Individual, the date of their last ISP meeting and the date of the next scheduled ISP meeting. This did not include (as requested) the date of the most recent ISP meeting and the date of the ISP meeting prior to the most recent. Therefore, the Monitoring Team could not assess whether the last ISP meeting had been held within 365 days after the one before.<br><br>Extent to which ISPs are put into effect within thirty days of preparation:<br>Monthly/Quarterly reviews indicated that individuals' ISPs were not consistently put into effect within 30 days of preparations. For example:<br>• For Individual #381, during the first three months following the ISP, it was noted that most new objectives were late being implemented.<br>• For Individual #191, the Monthly review indicated the QDDP was completing internet research on how to implement a Service Objective for four months following the ISP, with no information as to any of the results of the research.<br><br>Conclusion: This provision was found to be not in compliance due to the failure to hold and/or implement annual ISPs within the required timeframes. | |
| 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. | During the previous site visit, the Monitoring Team recommended that the Workgroup for Sections F, T and U 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. During this site visit, the Monitoring Team was pleased to find DSSLC was beginning to develop a thoughtful approach to quality assurance measures that identify and remediate problems to ensure that the ISPs are developed and implemented. In addition to the quality improvement initiative to improve the quality and timeliness of assessments described in Provision F1c, the Facility had developed an entirely new tool to monitor the ISP that integrated indicators from many of the Sections of the Settlement Agreement as well as other regulatory and compliance requirements. The Director of QA noted that the tool is still a work in progress. It currently has some 157 items that are to be reviewed during the ISP and then monitored for implementation two months later. The primary reviewers are a QA Auditor and the QDDP Coordinator. Inter-rater reliability is still being established. The process is very new and it was estimated that only six or seven had been completed thus far, and only two of those had the two-month follow-up. One completed ISP Monitoring Tool was reviewed. It had been completed by the QA Auditor and was very detailed and included much evaluative analysis of the ISP process.<br><br>Conclusion: This provision was found to be not yet in compliance. The Monitoring Team commends the Facility for its initiative in this area and looks forward to reviewing the | Noncompliance |

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| | | process as it matures. | |

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

1. Establish a clearer plan for measuring the outcomes of each Action Plan and include this in the Evidence column in addition to the paper compliance evidence currently found there. (Self-Assessment)
2. The Facility should update its Action Plans for improvement when outcomes have not yet been achieved. (Self-Assessment)
3. The State and Facility should reconsider how the new ISP process can be modified to better support plan meaningful participation by the individuals and a resulting plan based on an individual's personal goals, preferences and strengths. (Provision F1b)
4. IDTs should consider developing an individualized community participation plan, 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. (Provision F2a1)
5. Determine if a single format for Action Plans should be used throughout the Facility or whether it is permissible to use various templates. (Provision F2a6)
6. The Facility should consider implementing a quality improvement project for ensuring the required monthly review is completed. (Provision F2d)
7. 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. (Provision F2e)
8. Clear performance goals and outcome measures should be defined for Section F, along with appropriate methodology for analyzing the data. (Provision F2g)

| SECTION G: Integrated Clinical Services | |
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| 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:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment 9/24/12<br>2. DSSLC Action Plans 9/24/12<br>3. DSSLC Report for Monitors 10/8/12<br>4. Presentation Book for Section G<br>5. DADS Policy 009.1 Medical Care 9/6/12<br>6. DADS draft Policy #005: Minimum and Integrated Clinical Services 1/12/10<br>7. DSSLC Policy MED-01 Medical Care 8/17/10<br>8. DSSLC Policy CMGMT 03 Integration of Clinical Services 3/27/12<br>9. DSSLC ISP monitoring Tool (undated)<br>10. The Main Questions for Eternal and Internal Medical Provider Audits 5/7/12 and blank rating form<br>11. The Medical Management Questions for External and Internal Medical Provider Audits questions for aspiration, constipation, diabetes, osteoporosis, seizures, and urinary tract infections 5/7/12<br>12. Attendance sheets for "Morning Report" for each Wednesday from 4/18/12-6/27/12 and 8/8/12-10/10/12<br>13. Minutes of morning clinical services meetings of 5/9/12, 6/27/12, and 8/8/12<br>14. Consultation Report Form revised 7/6/12<br>15. Consultation form Primary Care Provider's Recommendation page for Individual #129 7/24/12<br>16. Modified Barium Swallow Study (MBSS) Guidelines 5/23/12<br>17. Physical and nutritional Management Team Minutes for 8/6/12, 8/20/12, 9/4/12, 9/15/12, 9/17/12, and 9/18/12<br>18. PSP Attendance—All Meeting Types 4/1/2012-8/31/2012<br>19. ISPs, CLDPs, and other documents reviewed by the Monitoring Team<br>**People Interviewed:**<br>1. Group interview of Nancy Condon, Facility director, Seven Kubala M.D., Director of Medical Services, Randy Spence, M.S., BCBA, Director of Behavioral Services, and Donna Groves, OTR Director of Habilitation Therapies<br>**Meeting Attended/Observations:**<br>1. ISP annual planning meeting for Individual #250<br>2. Morning clinical services meetings 10/10/12 and 10/11/12 |
| | **Facility Self-Assessment:**<br>The Facility submitted a Self-Assessment for Section G, dated 9/24/12. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating.<br><br>In conducting its self-assessment, the Facility: |

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| | • Used and reported on the outcomes of "medical provider quality assurance audits" for Provisions G1; for Provision G2, the self-assessment specifically listed reviewing external audits by non-facility medical staff and internal audits by facility medical staff.<br>o The self-assessment reported that audits were based upon a 5% sample at each audit.<br>o Data were not provided, nor was it made clear whether the improvement related specifically to provision of integrated clinical services and to whether appropriate facility clinicians reviewed recommendations from non-SSLC clinicians, or whether the finding was more generally about medical care. Therefore, the self-assessment did not indicate whether the Facility was using these audits to identify status on the requirements of these two provisions or status of medical care more generally. As a result, the Monitoring Team could not determine whether the Facility review of audits focused on indicators that would assist the Facility to determine compliance with either of these provisions.<br>o The self-assessment reported inter-rater reliability for the August 2012 audit was above 96%. The self-assessment for Provision G2 indicated there were both external and internal audits during August 2012; the self-assessment did not specify whether this reliability figure was for the external audit, the internal audit, or both.<br>o The self-assessment reported that reliability for the August 2012 internal audit was with a Quality Assurance Utilization Review certified physician. It did not indicate whether both auditors reviewed the entire 5% sample, or whether reliability was checked for a sample of those audits.<br>o Based on a review of the audits, the Facility reported audits showed improvement for both provisions but a need for continuing improvement<br>• Assessed attendance at Morning Provider meetings weekly to determine participation by clinical disciplines.<br>o The self-assessment did not report attendance data but did provide a list of disciplines that had "Regular attendance".<br>o Although regular attendance is an indication that a process is in place that might lead toward integrated services, the self-assessment did not report any process to measure or monitor integrated discussion and planning at these meetings. No data were provided on whether these meetings resulted in referrals to the IDT, to development of an ISPA, to other integrated clinical planning, or to referral for improvement of facility procedures.<br>• Assessed attendance at Incident Management Review Team daily meetings to determine participation by clinical disciplines.<br>o The self-assessment did not report attendance data but did provide a list of disciplines that had "Regular attendance" as well as other management and administrative staff who attended.<br>o The self-assessment did not report any process to measure or monitor integrated discussion and planning at these meetings.<br>• Reviewed attendance for Individual Support Plan meetings to determine if all clinical areas were attended.<br>o The self-assessment reported attendance at 100% for most team members.<br>o The self-assessment reported that a new audit was implemented in August to provide |

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| | better information related to the interdisciplinary team process.<br>• Reviewed clinical indicators to determine overall clinical trends.<br>o The self-assessment reported clinical indicators have been identified and are being reviewed regularly. It also provided a list of indicators that are showing steady improvement and stated action is being taken using data, but provided no further information about the actions and how they demonstrate integrated clinical service or ensure the individuals receive the clinical services they need. The self-assessment should include a status of the development of clinical indicators against the indicators planned for development and, for this provision, indicate how processes and outcomes demonstrate status of compliance with the requirements of integrated clinical services to ensure individuals receive clinical services they need.<br>• Did not report any process or data regarding review by the appropriate clinician of recommendations from non-Facility clinicians, nor whether the review and documentation included whether or not to adopt the recommendations or whether to refer the recommendation to the IDT for integration with existing supports and services. As this is the requirement of Provision G2, the self-assessment did not report an indicator that would allow the Facility to determine compliance.<br><br>The Facility rated itself as being not in compliance with either provision of this Section. The Monitoring Team concurs. |
| | **Summary of Monitor's Assessment:**<br>The Facility had continued to progress toward providing clinical services in an integrated manner Policies and processes to improve integrated planning both for individuals and for systemic improvements continued to evolve. Nevertheless, integrating planning and services across disciplines remained a challenge, and this provision was not yet in compliance. The Facility had made significant progress in documentation and follow up to recommendations from consultations by non-Facility clinicians.<br><br>There were numerous examples noted throughout this report of improvements in collaborative planning and case formulation. At the same time, there were examples in which notice of important conditions was not given to the IDT or there was no documentation f collaborative planning. Improvement still is needed in integrating planning for those supports and services for individuals and particularly in ensuring they are integrated into and become part of the ISP. The Facility must identify areas in which improvement in both the activities and documentation of integrated planning, and in the evidence that treatments and interventions involve integrated planning, are integrated into ISPs.<br><br>Facility physicians documented review of recommendations from non-Facility clinicians. There was no evidence of referral to IDTs on the consultation forms or integrated progress notes. |

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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 had continued to progress toward providing clinical services in an integrated manner Policies and processes to improve integrated planning both for individuals and for systemic improvements continued to evolve. Nevertheless, integrating planning and services across disciplines remained a challenge, and this provision was not yet in compliance.<br><br><u>Policy</u><br>DSSLC Policy CMGMT 03 had been revised. This purpose of this policy was to "provide integrated clinical services… to ensure that individuals receive the clinical services they need." This policy provided for and described a number of procedures, including among others the Daily Clinical Services Meeting, Psychiatry Clinic, Integrated Progress Notes (IPNs), Dental/Medical Treatment (which referred to sedation and to oral hygiene), Dental Desensitization Plans, committees (including Positive Behavior Support, Pharmacy & Therapeutics, Medication Variance, Infection Control, Physical and Nutritional Management, and Restraint Reduction), Quarterly Drug Regimen Reviews, IDTs, Community Living Discharge Plan, Physical and Nutritional Management Team, Chronic Care Visits, Health Management Plans, IMRT, and more. The descriptions included membership and purpose of committees and meetings, along with brief descriptions of processes. Beyond that, the policy did not identify other processes to ensure integration of services or means to assess whether integrated planning has occurred and has resulted in integrated plans. Nevertheless, it provides a good beginning in setting expectations and clarifying that integration of services is a purpose for these various committees and processes.<br><br>A draft DADS statewide policy had also been available for over a year. 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.<br><br>Through observations, interviews, and reviews of documentation, the Monitoring Team identified examples of both integration of clinical services and opportunities for greater integration. A few examples follow:<br>• As reported in Provisions J1 and J2, the psychiatrists participated meaningfully in the interdisciplinary process. Nurse case managers, psychologists, and direct support professionals (DSPs) provided information and participated in discussion during the psychiatric medication reviews.<br>• For Individual #61 the CPE of 9/18/12 stated that on 12/21/11 an evaluation | Noncompliance |

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| | | was done and "due to a direct correlation of mood changes with increased pain level diagnosis is changed from depressive disorder NOS to Mood Disorder – depressive type secondary to chronic pain. RN CM will follow-up with Primary Care Provider (PCP) regarding pain management." That note was direct, focused, informative, and substantive. It provided what was needed at the level of the CPE in terms of clinical justification. If more detail was needed, the primary materials could be located. This was an example of integrated care, since the re-diagnosis led to involvement of the medical team to address an underlying cause of distress.<br>• As reported in Provision J8 regarding completion of PBSPs in a new format that had been in place for one year, a key element was the inclusion in the PBSP of the section for a combined case formulation. The case formulation is an electronic copy of the bio-psycho-social formulation from the psychiatrist's CPE. While those case formulations are inclusive, they are nonetheless formulations written by a member of one discipline. PBSPs properly describe these summaries as "psychiatric case formulations" when they are included in the PBSP. While the case formulations written by the psychiatrists are a good basis for the combined case formulation, a stronger contribution from psychology is needed. Provision J8 stated progress has been made regarding integrated care at the level of the behavioral health care program, as reflected in the PBSP. Progress on behavioral healthcare integration at the overall level of the ISP was more limited. The example of Individual #141 reported in Provision K5 identifies ways in which this combined case formulation did not yet provide information that can be used in developing effective PBSPs.<br>• In addition to the combined case formulation section, the Facility revised (effective 01/23/12) the PBSP format to include a section called "Differentiation between Learned Problem Behaviors and Psychiatric Symptoms. These were present for four of 13 (31%) of the records.<br>• As reported in Provision J15, the Lead Psychiatrist informed that Monitoring Team that the Facility has started to do MOSES reviews whenever anticonvulsant doses were changed in the Neurology Clinic, not only for individuals who received dual-purpose medications, but for all anticonvulsant dose changes. Results were provided to the PCP and also to psychiatrists, for all individuals under their care. In many cases where anticonvulsants have been used for many years, psychotropic effects of those medications – positive and negative – become apparent only when the dose is changed and behavioral effects follow. The increased attention to tracking the behavioral effects of all anticonvulsant medications was positive, and was an example of well-integrated care.<br>• As reported in Section L, there were examples in which there was no | |

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| | | documentation that the IDT was made aware of diagnoses and in which there was documentation in the ISP of comprehensive review.<br>o For Individual #596, the IDT was not made aware, per review of the ISP and ISPAs, of the diagnosis of compression fracture and degenerative spine disease, each of which could affect the treatments and interventions planned by a range of clinicians.<br>o For Individuals #556, #205, and #33, the ISPs included specific documentation and comprehensive review.<br>o Out of five examples reviewed of individuals with diagnoses of malignancy, none had documentation in the ISP. Such a diagnosis requires a number of supports from a bio-psycho-social approach.<br>• As reported in Provision M1, the Hospital Liaison Nurses notified IDT members 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. These activities have resulted in a more integrated approach for care of the individuals served.<br>• The Infection Control Preventionist chaired the quarterly Infection Control Committee meetings. The Committee continued to take 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.<br>• RN Case Managers were responsible for drafting the Integrated Health Care Plan (IHCP) and Integrated Risk Rating Form (IRRF). As reported in Provision M5, other clinical disciplines frequently failed to provide the RN Case Managers with their data 10 days prior to the ISP annual planning meeting. This resulted in either the RN Case Managers spending a concerted amount of time researching other disciplines' clinical data or the data were missing from the risk assessments.<br>• Zero of 22 (0%) acute care plans (ACPs) indicated they were developed in collaboration with other relevant disciplines. However, one ACP was for decubitus care and included recommendations from the Wound Care Nurse.<br>• As reported in Section O, PNMPs were not clearly developed with input from all | |

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| | | members of the IDT or reviewed consistently by the IDT.<br>• Section P reported that an area of improvement was DSSLC's effort in responding to falls. The team has continued to respond more frequently and in a more comprehensive manner, especially over the last two reviews. While the response and comprehensiveness had improved, information obtained through these assessments as well as others was not integrated as part of the ISP in a way that was meaningful and functional to the individual. In addition, for individuals receiving direct OT and PT services, findings from assessments 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.<br>• Numerous examples were presented in Provision L1 of health and medical conditions that were not addressed in the ISP, including degenerative spine disease. However, PKU was appropriately addressed in ISPs.<br>• Section R reported progress in integration of communication therapy services into behavioral services planning, but with additional improvement needed. Based on review of five records for individuals in Sample #5, three of five communication assessments and PBSPs reviewed (60%) addressed the connection between the PBSP and the recommendations contained in the communication assessment, and four of five (80%) communication assessments reviewed contained evidence of review of the PBSP by the SLP. Review did not, however, always result in revision of the PBSP when a discrepancy was found.<br><br>Integrated participation and planning at various committee meetings also continued to evolve.<br>• As reported in Provision J11, Facility level review of polypharmacy took place at the monthly Polypharmacy Review Committee. Attendance at the meeting included psychiatrists and psychiatric assistants, PCPs, pharmacists, the lead psychologist, and other clinical staff. The Facility continued to use the PRC for issues that related to facility use of medication in a broad sense. For example, during the review period, the PRC reviewed the cumulative anticholinergic load that individuals experience regardless of the chemical class or clinical indication of the medications that have anticholinergic effects. In another example, the PRC has expanded its review of individuals who have metabolic syndrome. It was a well-run meeting led by the Pharmacy Director and there was a case-by-case review of individuals' circumstances. That discussion contributed meaningfully to integrated care, since attendance included the medical specialists from medicine and psychiatry and that facilitated joint discussion about the best medication combinations.<br>• As reported in Provision O1, the Physical and Nutritional Management Team | |

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| | | (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 an example, Individual #737 was reviewed by PNMT. Members of medical and clinical services were present and demonstrated comprehensive collaboration in the response to the individual having a fracture and the supports the individual would need. Also, PNMT minutes reported that Individual #279 was reviewed following hospitalization. Following IDT review, there were no changes in positioning schedule or risk action plans, but the IDT developed an individualized trigger sheet regarding pain and cloudy urine.<br>• A morning clinical services meeting was held each weekday. This had evolved from a medical meeting to a meeting involving a number of disciplines (although medical issues were observed to remain the focus). Each Wednesday, facility administrators were expected to attend, as many did at the 10/10/12 meeting (including the Facility Director, director of Community and Family Relations, pharmacy director, director of habilitation services, and others). At the Wednesday and Thursday meetings observed, attendance included the director of psychology, health services coordinator, psychiatrists, physicians, nurses including the hospital liaisons and skin integrity nurse, and infirmary nurse. The primary discussions at the two meetings involved on-call reports, hospitalization status of individuals, and infirmary report. One injury in the infirmary led to discussion and a plan to follow up with the investigation that had been initiated. No systemic issues were discussed, although reviews of minutes of meetings in May, June, and August 2012 identified systemic issues discussed. The Health Services Coordinator took notes throughout each meeting; she reported that she uses those notes to follow up on systemic issues. This meeting provides an opportunity both for integrated discussion regarding an individual's health status and supports and for review and recommendations on systemic issues. Although these two meetings primarily involved reporting with some discussion of individuals, they did not involve extensive integrated planning; this may have been simply due to the lack of any need for such discussion based on the issues reported at these two meetings; the Monitoring Team will observe these meetings at future visits.<br><br>The Monitoring Team reviewed records of attendance at annual ISP planning meetings and observed the planning meeting for Individual #250. Attendance by clinical staff at this planning meeting was excellent, with all appropriate disciplines represented. Only pharmacy was not represented. Based on information in a document provided by the Facility ("PSP Attendance—All Meeting Types), attendance at required meetings was 98%. However, some of the information in the document was puzzling, insofar as it did not support that all clinicians who might be needed were actually required to attend. For example, although the individual was required to attend 178 meetings (meaning that | |

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| | | there were at least 178 ISP meetings), the PCP was only required to attend two meetings (although there was also a category for physician, with 51 required meetings, but no indication of how "physician" differed from "PCP"), the QDDP was required to attend only 155, and a Psych III was listed separately from Psychologist/Behavior Analyst (which brings up the possibility that some of these individuals listed were considered "required" only if they attended, thus inflating the percent of compliance). This document did not list attendance by type of meeting, so it was not possible to determine from it what attendance was at annual ISP meetings, quarterly PBMCs, or other specific types of meetings.<br><br>Observation of the ISP planning meeting provided examples of integrated planning and of areas in which such planning could have improved.<br>• When discussing risk, some supports identified by the interdisciplinary team (IDT) indicated integrated planning. Supports related to cardiac risk addressed weight, exercise, and medication monitoring. Interestingly, although exercise was addressed under cardiac risk in relation to weight, it was not addressed under the risk for weight, although effects of medications were discussed.<br>• Discussion of weight risk included discussion of behavior problems at night related to requesting snacks as well as possible issues with sleep. There was a question of whether to have a sleep study. This was a good integrated discussion that crossed categorical and discipline boundaries.<br>• The DSP attending the meeting participated actively, responded to questions from clinicians, and provided information.<br>• Regarding skin integrity, supports identified included medical supports such as referral for a dermatology consult, special socks, and skin treatment, as well as behavioral supports through a PBSP. The speech and language pathologist talked about communication training as part of the PBSP.<br>• Discussion addressed the individual's schedule, preference not to participate in work, participation in direct speech therapy, and the possibility of exploring other work options. Although the discussion was interdisciplinary, the outcome did not lead toward identification of significant job exploration opportunities, changes in schedule, or new ideas for improving work tolerance. The discussion may have led the IDT members to continue to plan such options outside the meeting, but it was unclear whether this would occur.<br><br>Other information about attendance at ISP planning meetings indicated improvement is still needed. As noted above, though, the Facility was not able to provide data that tracked and summarized attendance.<br>• As reported in Provision P1, either an OT or PT but not both attended 83% of these meetings, attendance by both was documented for 11% of meetings, and | |

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| | | attendance by neither was found for 6% of meetings.<br><br>A new process (implemented in September 2012) for monitoring annual ISP planning meetings used an ISP Integrated Monitoring Tool that included questions that addressed integrated clinical planning. Several items specifically addressed questions of integrated planning, for example:<br>• #17 "Did the entire team give team recommendation in regards to living in a more integrated setting?"<br>• #50 "Did the IDT identify which disciplines are included in the risk action plans?"<br>• #56 "Were all team members needed in the risk discussion present?"<br>• #57 "Did the IDT discussion include integrated services to ensure that the individuals receive the clinical services they need? (i.e. general medicine, psychology, speech therapy, dietary, and occupational therapy)" (Note that this question specifically referenced Provision G1)<br><br>Because this was a new process, there was not yet information on Interrater reliability (to ensure different observers would define the items the same and rate the meetings the same), and there had not yet been an opportunity to identify trends or take corrective or improvement actions.<br><br>In summary, the Facility continued to make progress both in developing system process to provide opportunities and encourage integrated planning for individual services and Facility processes, and to develop integrated plans for services and supports provided to individuals. Improvement still is needed in integrating planning for those supports and services for individuals and particularly in ensuring they are integrated into and become part of the ISP. | |
| 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. | <u>Policy and Guidelines</u><br>In response to a document request for a copy of any Facility policy that guides Facility clinicians in performing and documenting reviews of recommendations from non-Facility clinicians, the Facility provided the Consultation Report form but no policy. The Facility stated in the response that "Facility policy that guides Facility clinicians in performing and documenting reviews of recommendations from non-Facility clinicians" was "Currently in draft review process." However, the Facility did have a policy; DSSLC Policy MED-01 Medical Care was dated 8/17/10 and had not yet been updated to be consistent with any changes to DADS Policy 009.1 Medical Care dated 9/6/12. Regarding consultation, DADS policy provided greater specificity of actions required of the facility primary care physician (PCP) than was provided in DSSLC policy. Among those requirements are contents of the consultation request; addressing consultant | Noncompliance |

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| | | recommendations in the progress note or back of the consult form, including documentation of whether the facility clinician agreed or disagreed with the recommendations, and documentation on the back of the consult form when recommendations are not implemented; and referral to the IDT if necessary. The Facility needs to update its policy.<br><br>The Facility provided a flowchart titled Modified Barium Swallow Study (MBSS) Guidelines. This flowchart provided pathways for review by the Occupational Therapist (OT) and notice to the PCP and IDT based on the results of the MBSS. It provided a process for discussion at the morning IMRT meeting if any IDT member disagrees with the IDT recommendation to place or not to place an enteral feeding tube. It provided a list of actions to be taken by the primary care physician (PCP) and IDT if an enteral feeding tube is to be placed.<br><br><u>Procedures and Forms</u><br>The Consultation Report form had been revised 7/6/12. This form included on the first page the consultation request and the findings and recommendations from the consultant. On the second page, the PCP was to document whether the recommendations were to be adopted, rejected, or adopted partially. The form had a place for explanation of rejection or partial adoption. There was a checkbox indicating whether to refer the recommendations to the IDT for integration with existing supports and services. This would meet the requirements of DADS policy noted above.<br><br>The Facility provided a sample of the second page of the form for one consultation involving Individual #129. For this individual, the box marked "Adopt Consultant's Recommendations was marked, and the "No" box about referral to IDT was marked. Although the form included no explanation for the decision not to refer, the section for Explanation (Plan of Care) documented that present care and scheduled injections were to be continued; thus, it appeared plausible that the PCP did not refer this to the IDT because there was no recommendation to revise the ISP.<br><br>Ten consult reports were reviewed for Individuals #121, #122, #252, #299, #334, #462, #482, #602, #616, and #735. Nine of 10 (90%) included a signature or initial documenting review by the Facility physician. For each of the nine documented reviews (100%), the Facility physician documented agreement with the recommendations; for eight (89%), the physician provided an integrated progress note (IPN). For the one for which no IPN was written, the physician provided documentation of a plan on the consult form. For the consult for Individual #121, the Facility physician did not indicate review or agreement on the consult form but did write an IPN that provided a good explanation and plan. Physicians had greatly improved on documentation and follow up to | |

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| | | consultations. None of the ten sampled consultations were referred to the IDT for further review and action; for some, but not all, the clinician checked the box on the consult form indicating a decision not to refer.<br><br>In addition, there were 27 Physiatry and/or Orthotic related consults. The DSSLC Physician showed acceptance of the consults 27 of 27 times (100%) using the "Primary Care Provider's Recommendation" form.<br><br>The Facility had made significant progress in documentation and follow up to recommendations from consultations by non-Facility clinicians. To gain compliance, the Facility must complete development and implementation of policy guiding this process for all clinical disciplines, and must ensure recommendations are referred to the IDT for review and action as appropriate. | |

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

1. Add to the draft DADS policy by specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring. (Provision G1)
2. Consider revising the Facility policy on integrated clinical services to identify other processes to ensure integration of services or means to assess whether integrated planning has occurred and has resulted in integrated plans. (Provision G1)
3. 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, treatment and intervention plans, and the active record. (Provision G1)
4. Ensure assessments are developed timely and posted for review by IDT members in preparation for annual ISP planning meetings. (Provision G2)
5. Update the Facility policy to include requirements for consultation request and review found in DADS policy. (Provision G2)
6. Implement either a process of routine review by the IDT of consultation recommendations or a process to ensure referrals to the IDT when appropriate. (Provision G2)

| SECTION H: Minimum Common Elements of Clinical Care | |
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| 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:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment 9/24/12<br>2. DSSLC Action Plans 9/24/12<br>3. DSSLC Report for Monitors 10/8/12<br>4. Presentation Book for Section H<br>5. DADS draft policy #005: Minimum and Integrated Clinical Services 1/12/10<br>6. DSSLC Policy CMGMT 03 Integration of Clinical Services 3/27/12<br>7. DADS policy 009.1 Medical Care 9/6/12<br>8. DSSLC Policy MED-01 Medical Care 8/17/10<br>9. Action Plan Considerations undated<br>10. Attendance sheets for "Morning Report" for each Wednesday from 4/18/12-6/27/12 and 8/8/12-10/10/12<br>11. Clinical Services Meeting Notes for 5/9/12, 6/27/12, 8/8/12, and 9/12/12<br>12. Memo describing meetings held with individual PCPs (undated, unsigned)<br>13. Minutes of Providers Meetings of 6/12/12 and 6/25/12<br>14. Memo of 8/31/12 from Lori Johnson to Clinic Clerks/Records Clerks Re: Scanning (of consults, test results, W-rays, and hospital records)<br>15. List of clinical indicators August 2012<br>16. Data Analysis Report for QA/QI Council Meeting of 10/9/12<br>17. Graphs of timeliness of assessments by Unit, by discipline, by discipline within each unit, and by apartment, April-September 2012<br>18. Memo of 7/16/12 from Lori Johnson to Clinic clerks/Clinic nurses re Annual Physical summary schedule<br>19. Graphs of % of compliance with quality measures for OT/PT (Occupational Therapy/Physical Therapy) and Vocational Assessments, QDRRs (Quarterly Drug Regimen Reviews), and FSA (Functional Skills Assessment) for August 2012<br>20. Key Performance Indicator Worksheet for Assessments, undated<br>21. Corrective Action Plan for Assessments 5/25/12<br>22. Scoring forms for audits of assessments:<br>a. Vocational<br>b. Functional Skills<br>c. Physician<br>d. QDRR<br>e. OT/PT<br>f. Speech-Language (Communication)<br>g. Psychiatric<br>23. Training agenda and materials on enhanced risk<br>24. Minutes of Physical and Nutritional Management Committee Spasticity Meeting 8/21/12 |

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| | 25. Spasticity Protocol 2/23/12<br>26. DADS Information Letter No. 12-74 August 24, 2012 re: Implementation of the International Classification of Diseases, Tenth Revision, Clinical Modification<br>27. Procedures: Entering Axis III/ICD9 Diagnoses in Avatar<br>28. Chronic Problem Progress Records for Individuals #247, #248, #648, and #799<br>29. Monthly Infection data report January-July 2012<br>30. Graph of all infections January 2011-May 2012<br>31. Pneumonia/aspiration tracking sheet<br>32. Skin and Soft Tissue Infections Monthly Report 2012<br>33. Individuals with Stomal Irritations Per Home/Month with accompanying analysis, corrective action plans, and follow-up report<br>34. Infection Incidence for 512C from 1/1/12-4/30/12<br>35. Graph of decubiti January 2010-May 2012<br>36. Email of 9/28/12 from Diane Porter, RN, to Elena J Slay, RN, and Stephen Kubala, MD re diabetic management trends<br>37. Diabetic Management Review 9/14/12<br>38. ISPs, assessments, CLDPs, and other documents reviewed by members of the Monitoring Team, as identified in other sections of this report<br>**People Interviewed:**<br>1. Group interview of Nancy Condon, Facility director, Seven Kubala M.D., Director of Medical Services, Randy Spence, M.S., BCBA, Director of Behavioral Services, and Donna Groves, OTR Director of Habilitation Therapies<br>**Meeting Attended/Observations:**<br>1. Morning clinical services meetings 10/10/12 and 10/11/12 |
| | **Facility Self-Assessment:**<br>The Facility submitted a Self-Assessment for Section G, dated 9/24/12. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating.<br><br>In conducting its self-assessment, the Facility:<br>• Identified specific indicators relevant to the requirements of the individual provisions. These included, among others:<br>o The medical quality assurance audit completed by a quality assurance physician in August 2012. For some provisions, the self-assessment involved review of specific audit items relevant to those provisions.<br>o Data on tracking annual assessments by physicians.<br>o Trend data on specific health indicators such as pneumonia, pseudomonas infections, hospitalizations, and deaths.<br>o Use of ICD-9/DSM IV diagnoses on the medical database<br>o Determination of use of clinical indicators in a sample of records from each provider<br>o Tracking of clinical indicators by the Physical Nutritional Management Team (PNMT) |

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| | • For some audits and reviews, 100% of items were reviewed (such as tracking of annual assessments by physicians); in other cases, samples were used (such as review to determine whether clinical indicators were used in records). Sample sizes were reported for the audits of use of clinical indicators but not for the medical audits or the tracking of chronic care quarterly visits. When sample sizes are not reported, it is not clear whether they provide a representative sample to allow the Facility to assess its status accurately.<br><br>The use of trend data on key clinical indicators noted above provides outcome measures that can demonstrate effectiveness of the processes in place, and are therefore useful in assessing status of movement toward compliance.<br><br>Although specific indicators were provided, the reports of results did not always provide data or did not match the statement of the activities. Therefore, it was not always clear that the indicators and audit processes were adequate to allow the Facility to determine compliance with the Settlement Agreement. For example:<br>• Reports of trend data summarized that there was progress ("steady decline" or "steady improvement") but did not provide data that could be used to identify whether the improvement had yet brought the Facility into compliance with the provisions. Presumably, data were used to identify that there was improvement, but they were not reported in a way that Facility staff and administration would have the information available for decision-making. Furthermore, the report of improvement listed a number of different conditions or indicators that had improved, and the lack of data made it impossible to determine the significance of improvement in each condition or indicator.<br>• Although the self-assessment stated that improvement had occurred (based on results of the most recent medical audits, although the one item listed did not seem relevant to this issue), audits showed improvement was still needed in documenting clinical indicators. No data were provided that could be compared from one self-assessment to the next.<br>• Although there was an activity for Provision H5 to review tracking of clinical indicators by the PNMT, the results reported were the number of individuals followed and reviews done by the PNMT, and that the PNMT continues to meet regularly; there was no evidence that there was tracking of clinical indicators or of decisions made as a result of such tracking.<br><br>Except for determination of Interrater reliability on the internal medical audit (as the self-assessment reports for Provision H5), there was no indication that determination of reliability was done for any other audits<br><br>The self assessment did not provide fully adequate indicators to allow the Facility to determine compliance with the Settlement Agreement.<br>• For Provision H1, the only clinical discipline for which the activities included reviewing assessments was physicians. There was no review reported for other clinical disciplines such as physical and occupational therapy, psychology, or nursing. It was clear from documentation provided at the Facility that assessments from all these disciplines were tracked, and the Facility |

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| | was taking action to improve timeliness. This should be included as part of the self-assessment for this provision.<br>• For Provision H2, the activities included reviewing the medical database to verify use of ICD-9/DSM IV diagnoses, ensuring the most recent versions of those were available for use, and auditing records for accuracy related to the active problem lists and diagnoses (but no description of what size sample was audited or how individual records were selected for audit). However, there was no activity to assess whether diagnoses clinically fit corresponding assessments or evaluations.<br>• As noted below, the self-assessment included an adequate review to assess whether physicians modified treatments and interventions in response to clinical indicators but did not include such a review for other clinical disciplines.<br>• Provision H7 self-assessment should identify specific indicators of status on the general activities and results. For example, it should identify which facility policies are needed and status of each, which clinical pathways need to be refined, and data on completion of assessments.<br><br>The self-assessment did, however, provide some specificity needed to ensure both appropriate and clear indicators were identified and reviewed, and that the indicators included a broad enough range of indicators to allow the Facility to assess a requirement of a provision. For example, for Provision H6, the Facility reviewed and reported on specific questions within the medical provider quality assurance audits; these were relevant to the requirement that treatments and interventions shall be modified in response to clinical indicators, and covered several conditions for which indicators had been established and which should be representative of the response of physicians to clinical indicators. However, there was no similar review of response of other clinical disciplines to clinical indicators.<br><br>The Facility reported that no provision of this Section was yet in compliance. The Monitoring Team concurs but does recognize significant improvements that have occurred, such as in development and use of clinical indicators for tracking systemic status of health, as well as initiatives that have begun and that have promise to resolve issues, such as the review of timeliness and comprehensiveness of assessments.<br><br>The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. The Action Plan provided an extensive list of actions to be taken for each provision. The majority of actions were listed as "Complete" with the remainder "In process." Some were specific and were identified in the self-assessment, such as implementation of the medical provider quality assurance audit process. Others did not list actions in a way that made clear exactly what would be done or how completion could be affirmed; for example, action H.7.3 stated that clinical indicators, pathways, PNMT, chronic care quarterly visits, and several other processes will provide basis for modifying treatments; although rated as Complete, the evidence for completion was "Medical QA audits," and review of the self-assessment for Provision H7 did not include review of medical provider QA audits or of specific relevant questions from those audits.<br><br>Areas the Facility identified in the self-assessment areas needing improvement were addressed. For example, the self-assessment stated that improvement was needed in documenting clinical indicators, and |

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| | the Action Plan stated that "Use clinical indicators to improve health care system" and assess assessments to ensure they include clinical indicators were in process. As the self-assessment evolves to include all requirements of provisions and more comprehensive review of data, more areas of needed improvement may arise; the Facility should continue to ensure these are addressed in Action Plans. |
| | **Summary of Monitor's Assessment:**<br>The Facility had continued to work diligently on improvements in timeliness and comprehensiveness of assessments, development and use of clinical indicators, and maintenance of systems to address chronic conditions, and is approaching compliance with several provisions. As these develop, the Facility will need to ensure policies provide guidance, and the systems are organized so it is clear how all come together to meet the needs of individuals for supports and services and also affect system wide improvement.<br><br>An example of such an organized process is the diabetic management system. The Diabetic Management Review of 9/14/12 not only provided data on incidence of hypoglycemia and hyperglycemia but also provided an evaluation of the status of the Facility on these and a comparison of how current data compared to past data. It also reported that the diabetic educator began trending this incidence as related to time of day as a next step in identifying obstacles to improvement (and, presumably, means to address those obstacles). This kind of approach should provide a model for reviewing and addressing health status issues.<br><br>The Facility had taken actions to improve on both timeliness and comprehensiveness of assessments. Although these actions were still in early stages, there was some evidence of improvement in timeliness of annual assessments. Assessments in response to changes in status remained more variable.<br><br>Diagnoses were consistent with the current versions of the DSM and ICD classification systems. For the most part, medical and psychiatric diagnoses generally matched assessments, and assessments usually provided adequate supporting information to support diagnoses. However, documentation did not always include all needed information to support diagnoses, and assessments and results from X-rays, labs, or other tests in some cases indicated a diagnosis that was not listed or for which additional testing did not occur in order to confirm or rule out a diagnosis.<br><br>The Facility had continued to develop systemic clinical indicators of efficacy of treatments and interventions in health care and other clinical areas. Many of these indicators had become integrated into the key indicators used by the Facility for quality review. Others were being used routinely in reviewing health and behavioral status of individuals. However, at an individual level, it was not always clear that the indicators were well-defined and were clinically justified, and that modification of treatments and interventions reflected the use of the indicators in identifying when changes in status required them.<br><br>The Facility provided a table of clinical indicators, with the reviewing authority and frequency of review of each. Items might be reviewed monthly, quarterly, annually, or upon request. This table provided an easy reference that could be used to identify who would have information and to guide auditing for documentation of review. The Facility did not provide information on monitoring to ensure reviews took |

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| | place, other than the reports provided to the QA/QI Committee. The Facility did provide tables and graphs of clinical indicator data and demonstrated an ability to break down these data into information by Unit, apartment, and individual in order to assist in making decisions.<br><br>Regarding policy development and implementation, the Facility needs to update its policy on medical care to reflect and operationalize revisions in DADS policy. DADS needs to complete revision of policy on minimum common elements of clinical care and needs to ensure the policy addresses all areas of clinical care.<br><br>The Facility had made significant progress on most requirements of this Section. |

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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. | <u>Timeliness and Comprehensiveness of Regular Assessments</u><br>Provision of assessments on both a regular basis and in response to change in health or behavioral status was not consistent across all disciplines. Data provided by the Facility indicated a need for improved timeliness. It is important for the assessments to be completed prior to planning meetings to permit the IDT members to review assessments from other disciplines so they can have information needed for collaborative and integrated planning of services and supports.<br><br>DSSLC recognized this issue and had begun an initiative to improve both timeliness and quality of assessments. The Facility administration described this as an "Assessment of Assessments." The process included tracking timeliness of annual assessments and auditing quality of assessments using scoring templates that had been drafted and had recently begun to be used. The scoring templates were also designed to lead to changes in templates for contents of assessments; the annual physician's summary was redesigned so providers use clinical indicators to plan how they will measure status for each specific problem. This process had begun only recently, and it would be expected to take some time before auditing of assessments would lead to improved and compliant assessments for all individuals. However, data on timeliness showed improvement in September for all units and nearly all disciplines compared to the prior five months. According to graphs provided by the Facility, more than 80% of assessments were provided 10 or more days before the annual ISP planning meeting for six of the seven living units (86%) in September. As there was only one month of improved performance by the time of the compliance visit, the Facility could not ensure this would continue, but it demonstrated the potential to resolve a longstanding problem. The ability to break down the data by discipline for each living unit, or by living unit for each discipline, provides information that allows the Facility to target efforts for improvement.<br><br>Furthermore, the Facility had recently initiated a management oversight process | Noncompliance |

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| | | operating from the QA Department. The database developed to support this process identified assessments due by date by Individual. This generated a "reminder" to the appropriate discipline coordinator. A similar identification and reminder occurred if the assessment was not completed on time. The Facility had begun to take administrative action with specific staff that remained noncompliant with policy requirements for timely assessments. The preliminary results of this new process were encouraging. In all assessment areas the percentage of compliance increased from August to September. For example, the timeliness of medical assessments increased from 50% compliant to 90% compliant. The timeliness of vocational assessment increased from 55% compliant to 90% compliant. The Monitoring Team reviewed the timeliness of assessments for eight ISPs held during the week of the monitoring visit and found most assessments were completed on a timely basis. The only consistent exception was the psychiatry assessments; when present, they were consistently completed only a day or two before the ISP. It was also noted that communications assessments were sometimes very dated, including two that were more than ten years old. Finally, a review of assessments available for an upcoming ISP due within the next ten days demonstrated 94% of timeliness overall for those assessments that were present, with 69% completed 10 days prior to the ISP meeting date. The Facility was not yet able to evaluate whether all needed assessments were present, as it did not have an individualized list of required documents. Therefore, this was not assessed.<br><br>There was variation in findings regarding whether there were improvements in comprehensiveness of assessments. Some examples of the status of assessments at the Facility included:<br>• As reported in Provision K5, it appeared that some confusion existed at DSSLC regarding Psychological Assessments. As requested by the Monitoring Team, the Facility was to include a document that provided, "An alphabetical list of individuals, including the type/name of their most recent psychological assessment and update, and the date on which the assessment and update occurred." Although the Document Request included this document, the document listed only the most recent functional assessment. The functional assessment, titled Psychological/Functional Assessment, at times presented intellectual and adaptive assessment scores, but did not provide a full interpretation of those results. DSSLC had developed and implemented a separate document for reporting and interpreting intellectual and adaptive testing results, but neither this document nor the intellectual and adaptive testing was provided in response to the request. Due to the lack of data provided, additional records and documents were reviewed in an attempt to obtain the necessary information. The only evidence regarding Psychological Assessment compliance was included in the Facility Self-Assessment. This evidence consisted of a single statement that, "145 individuals of 494 (30%) | |

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| | | have current psychological evaluations within the past five years." There was no indication of how many of the psychological evaluations had been completed within the past year, whether the reports included intellectual testing completed within five years, or whether the reports included adaptive testing completed within the past year.<br>• As reported in Provision O2, individuals were not provided with comprehensive annual assessments.<br>• OT/PT assessments were completed in accordance to the schedule set forth by DSSLC; however, they were not comprehensive as they lacked objective measurements and detailed information that allowed for comparative annual analysis. A new Assessment of Current Status format was in use at the Facility and included assessment by OT and PT. Based upon initial review, the new format should address the concerns that have been raised in previous reports regarding lack of comparative analysis directly related to past components of the initial comprehensive evaluation.<br><br><u>Assessments and Evaluations in Response to Changes in Status</u><br>As with routine assessments, there was variation in findings regarding whether there were improvements in comprehensiveness of assessments.<br><br>There were examples in which there was not evidence of assessment being done in response to changes in an individual's status, as indicated by the following:<br>• As reported in Provision I2, of 18 records reviewed, the most recent risk assessment reported a change in status for five. In two of these five (40%) the assessment process started within five days. Based on a review of nursing risk assessment records of a sample of six of these individuals, three (50%) included an adequate nursing assessment to assist the team in developing an appropriate plan.<br>• Individuals who had a significant history of PNM issues were not consistently identified and provided with the needed assessments.. Per review of eight individuals diagnosed with pneumonia and/or choking; Eight of eight (100%) were discussed at the PNMT or Interdisciplinary Team (IDT) meeting but a concern by the Monitoring Team was that all individuals who were in need of a comprehensive PNMT evaluation were not consistently provided with one. Out of the six individuals who were diagnosed with pneumonia, only two (33%) were provided with a comprehensive assessment by the PNMT. On a positive note, when individuals were identified as needing assessments, the assessments were comprehensively provided by the PNMT.<br>• As reported in Provision P1, assessments were not being consistently completed in response to a change in status. | |

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| | | There were also practices and examples that reflected improved response to changes in status, such as the following:<br>• During the Morning Meetings at the Infirmary, the Hospital Liaison Nurses provided a report on individuals who were in the hospital and their projected discharge dates. The on-call physician provided a report of calls received overnight and/or over weekends and holidays. Once a week there was a full integrated meeting that included representatives from all clinical disciplines. The need for referrals and follow-up were discussed regarding individuals identified with a change in status.<br>• An OT/PT comprehensive Assessment was in place and provided upon admission and as indicated by a change in status.<br><br>The Monitoring Team agrees with the Facility that the current status of both timeliness and quality does not permit a finding of substantial compliance. | |
| H2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems. | Diagnoses were consistent with the current versions of the DSM and ICD classification systems. As reported in Provision J2, the Active Problem Lists reviewed for the 15 individuals in Sample J2 contained up-to-date psychiatric diagnoses in the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) IV format. The Monitoring Team did not identify any medical diagnoses that were inconsistent with the ICD-9 classifications. Clerks and nurses were provided training on use of drop-down boxes in the electronic documentation so that only accepted diagnoses are entered.<br><br>In preparation for replacement of ICD-9-CM by ICD-10-CM (which Centers for Medicare and Medicaid Services announced would be effective 10/1/13 but has now proposed 10/1/14), DADS send Information Letter 12-74 encouraging providers to begin preparing.<br><br>For the most part, medical and psychiatric diagnoses generally matched assessments, and assessments usually provided adequate supporting information to support diagnoses. However, as reported in Provision J6, only 46% of evaluations in the sample reviewed by the Monitoring Team fully substantiated the psychiatric diagnoses in terms of all the symptoms required to fulfill the diagnostic criteria listing in the DSM IV TR or Diagnostic Manual of Intellectual Disability (DM-ID). Continued improvement is needed.<br><br>Furthermore, there were several examples reported in Provision L1 in which assessments and results from X-rays, labs, or other tests indicated a diagnosis that was not listed, or for which additional testing did not occur in order to confirm or rule out a diagnosis. For example: | Noncompliance |

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| | | • For Individual #581, a blood count indicated macrocytosis with low red blood cell count, and there was no evidence documented the etiology of these findings, nor was macrocytosis listed as a diagnosis or problem.<br>• For Individual #704, X-rays of the spine demonstrated degenerative spine disease, and degenerative disc disease. Neither of these issues were listed as a diagnosis.<br><br>The Facility needs to develop a process to assess whether all assessment documentation is provided to support diagnoses, including providing rationales for diagnoses, and to ensure that diagnoses match information from diagnostic testing or rationales for not listing such diagnoses are documented. | |
| 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 procedures in place to ensure or monitor that treatments and interventions were implemented timely. Several provisions of this report provide examples in which treatments and interventions were not provided timely or were not clinically appropriate based upon assessments and diagnoses. However, the Facility had continued to make strides toward ensuring 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. Outcome data provided by the Facility, including incidence of pneumonia and mortality rate as well as use of restraint for crisis intervention, indicated that improvements in timeliness and appropriateness of treatments and interventions may be having an effect.<br><br><u>Timeliness of Implementation</u><br>Timeliness of implementation was variable.<br>• As reported in Provision K9, 84% of PBSPs that had been submitted for review and approval since 5/1/12 had been implemented by the end of the compliance visit. The process for approval and implementation led, in some cases, to extended delays.<br>• Work done with local hospitals to make information from hospitalizations available more rapidly allowed IDTs to meet prior to the individuals' discharge to identify and put any new supports and services in place prior to their discharge.<br><br><u>Clinical Appropriateness</u><br>• As reported in Provision L1, plans were not in place to address some medical issues identified for individuals, but there were also examples of comprehensive and appropriate plans.<br>o For Individual #416, the individual had laboratory confirmation of | Noncompliance |

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| | | macrocytosis but no documented medical plan to address it.<br>o For Individual #622, for conditions identified by the physician, the medical plan documented on the annual physical assessment was excellent, and should serve as a model example for completing a medical plan.<br>• As reported in Provision K4, modifications to the PBSP generally reflected data-based decisions. Of the 18 records reviewed, 14 (78%) reflected reliance upon data to support treatment decisions. In the majority of these 14 records, the Individual was making progress toward the treatment objective and no revision to the PBSP was necessary. The records also reflected, however, that the Facility was not consistently quick to respond when data reflected the potential need for a revision to the PBSP. For example, Individual #33 experienced a spike in physical aggression in May 2012. Although physical aggression rates remained elevated for several months, Facility documentation did not reflect recognition that assessments should be reviewed or that revisions to the PBSP should be considered.<br>• Only 1% of individuals at the Facility received direct OT services, and 2% received direct PT services. Other than direct therapy services, the primary support provided was via the PNMPs. Given the number of individuals with musculoskeletal, movement, and ambulation difficulties, this would indicate that not all received services as appropriate. As reported in Provision P2, individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. | |
| 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 continued to develop systemic clinical indicators of efficacy of treatments and interventions in health care and other clinical areas. Many of these indicators had become integrated into the key indicators used by the Facility for quality review. Others were being used routinely in reviewing health and behavioral status of individuals.<br><br>The Facility provided a table of clinical indicators, with the reviewing authority and frequency of review of each. Items might be reviewed monthly, quarterly, annually, or upon request. This table provided an easy reference that could be used to identify who would have information and to guide auditing for documentation of review. The Facility did not provide information on monitoring to ensure reviews took place, other than the reports provided to the QA/QI Committee.<br><br>The Facility did provide sets of data, including:<br>• A table of infections by type, monthly for January-May 2012, including incidence rate for each. | Noncompliance |

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| | | • A table of decubitus by stage, monthly from January 2010 to May 2012, and a graph of total decubitus monthly<br>• A graph of monthly total infections from January 2011-May 2012<br>• A table of pneumonia/aspiration pneumonia tracking from January-May 2012, with totals, numbers by Unit, and individuals diagnosed with aspiration pneumonia<br>• A Skin and Soft Tissue Infections Monthly Report for January-April 2012, with monthly incidence, and number due to stomal irritations versus other infections total and by Unit, and a list of individuals with stomal irritations monthly by home<br>• A table of infection incidence by type of infection and month for apartment 512C 1/1/12-4/30/12<br><br>Although these tables were not accompanied by any documentation of review, assessment, and actions, the table for apartment 512C showed the ability of the Facility to break down the information in a way that will provide essential information in planning improvements. The availability of these data was a major step toward using such clinical indicators of efficacy to lead toward improved services.<br><br>The Facility provided four Chronic Problem Progress Records. These provided a template for routine review of individuals who had chronic conditions. They identified the chronic problem or system being addressed, vital signs and other observations, dates of labs, assessment of systems, and a plan. Other than vital signs, weight, and waist circumference, they did not include any data on clinical indicators that might be reviewed, reported, and assessed as part of determining a plan. As part of such a review, it would be helpful to note the clinical indicators being considered when assessing status.<br><br>The PNMC in collaboration with the QA department had developed clinical indicators that assisted DSSLC in establishing facility systemic trends. Among the clinical indicators reviewed by the PNMC on a monthly basis was:<br>• Hospitalizations<br>• ER visits<br>• Deaths<br>• Skin Integrity<br>• Enteral Nutrition<br>• Aspiration Pneumonia<br>• Pneumonia<br>• Falls<br>• Diabetes Management Report<br>• Individuals followed by PNMT and the PNMT's level of involvement | |

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| | | • UTIs<br>• Pseudomonas<br>This list was nearly the same as the indicators listed for monthly PNMC review in the table; the table did not include hospitalizations, ER visits, deaths, or skin integrity (except for skin/soft tissue infections) but did include conjunctivitis, UTIs, and MDROs. It would be good to reconcile the lists so expectations would be clear and consistent.<br>Nevertheless, it is clear that the Facility is making a serious effort to ensure that clinical indicators are identified, and that review is assigned.<br><br>The Diabetic Management Review of 9/14/12 not only provided data on incidence of hypoglycemia and hyperglycemia but also provided an evaluation of the status of the Facility on these and a comparison of how current data compared to past data. It also reported that the diabetic educator began trending this incidence as related to time of day as a next step in identifying obstacles to improvement (and, presumably, means to address those obstacles). This kind of approach should provide a model for reviewing and addressing health status issues.<br><br>The Facility reported a successful example of an improvement action taken as a result of review of clinical indicators. Data showed an increase in urinary tract infections. The Facility reviewed the data and implemented actions including retraining and monitoring on proper cleaning and washing of women who have a toileting accident and on handwashing, as well as ensuring adequate fluid intake. The Monitoring Team did not review data from August through October to determine effectiveness of these actions but does note that this is an excellent example of using data to identify actions to take.<br><br>Certainly, clinical indicators of health status were used routinely in making decisions on health and behavioral services. However, it was not always clear that the indicators were well-defined and were clinically justified, and that modification of treatments and interventions reflected the use of the indicators in identifying when changes in status required them.<br>• The Facility did not provide documentation of identification and listing of clinical indicators for specific common and significant diagnoses, such as osteoporosis, seizures, hypertension, and constipation. However, the continuing identification and review of hypoglycemia and hyperglycemia as an integral component of the diabetic management program provides a model that could easily be replicated to make clear clinical indicators of treatment efficacy both for the medical diagnoses listed above and for other clinical areas of care common to the IDD population, including psychiatric concerns, obesity, gastroesophageal reflux disease, communication issues, and oral hygiene.<br>• As noted above, the chronic care reports, while they provided an excellent | |

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| | | template and a great deal of information, did not include information on the clinical indicators of the conditions being assessed; therefore, there was no way to identify whether they were considered as decisions on treatment were made. However, as reported in Provision L1, other documents reviewed by the Monitoring Team did identify the review of clinical indicators, such as HBG-A1C blood test for each individual with diabetes reviewed.<br>• As reported in Provision J3, criteria for monitoring of efficacy of treatment with psychotropic medication were reported in PBSPs; however, there were difficulties such as lack of definition of symptoms, clarity on how severity was assessed, and lack of clarity on whether data reflected frequency or severity.<br>• As reported in Provision O3, the triggers listed on the Physical and Nutritional Management Plan (PNMP) identify actions that may increase the risk of an undesired event. Aspiration trigger sheets were used to report occurrence of triggers. However, the triggers listed on the aspiration triggers sheets did not always match those on the PNMP and were not always individualized enough to identify changes in status that need to be addressed.<br>• As reported in Provision P1, OT/PT assessments did not routinely include analysis that compared the individual's status with previous years or assessments.<br>• As reported in several examples in Provision L1, the outcomes of lab and radiological studies did not always lead to appropriate follow-up assessment.<br><br>The annual physicians summary was revised to promote use of clinical indicators; this was done recently and will be monitored and reviewed as part of an "assessment of assessments" process. Although the template for the report does not specifically prompt listing of clinical indicators or rationale for recommendations based on indicators, the scoring criteria for review do include whether there are clinical indicators for the past and future for each active problem. Although some of the other assessment scoring templates implied or stated that certain information was needed, none specifically indicated the need for data from clinical indicators as part of current or future assessment of status.<br><br>An area of improvement was noted with regards to the team's response to falls. Since the last compliance visit, DSSLC had developed a Fall Prevention manual that included performance indicators and methods of reporting falls, as well as strategies for identification and amelioration of risk, and a process for Facility-level review of falls by a team that included the directors of habilitation and behavioral services, the chief nurse executive (CNE), and administrative staff. Performance indicators included the number of falls, number of injuries related to falls, and the reduction of falls for the top five individuals with the most falls. This has the potential to use performance (clinical) | |

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| | | indicators to identify means to reduce falls and injuries through both environmental modifications and changes in treatments and interventions. The Monitoring Team will look forward to seeing how these indicators are used to identify root causes, and opportunities for changes in treatments and interventions at both system and individual levels.<br><br>The Facility had made major gains in identifying and tracking clinical indicators, especially at the system level. Data systems had been developed that could break the data down to Unit, apartment, and individual levels, which could assist in identification of areas to provide additional attention and review. Improvements in outcomes indicated the possibility that these processes had begun to have an effect. However, at a system level, there were only a few indications that these had led to specific actions, and it was not yet clear that the use of clinical indicators had reached the level of specificity and attention needed to affect treatments and interventions at the level of individuals. The Facility has come close to reaching compliance with this provision. It will need to provide more clarity in its use of clinical indicators to ensure the indicators are clinically justified and useful for affecting decisions on treatments and interventions for individuals, and provide documentation that use of such data affects system wide actions over time. | |
| 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 had continued to use several systems to monitor the health status of individuals, including the following:<br>• Clinical indicators, as reported in Provision H4<br>• The chronic care quarterly visit process<br>• Regular review by the Physical and Nutritional Management Committee (PNMC). As reported in Provision L1, the medical director informed the Monitoring Team clinical indicator data was being collected for analysis by the QA department, and was reported at the PNMC meetings. At some meetings, there was substantive review of data on pneumonia and diabetes; at others, some data were presented but minutes did not reflect analysis. The role of this committee had clearly expanded to review of a wide range of health issues.<br><br>In addition, the Physical and Nutritional Management Team followed the status of individuals who have been referred.<br><br>Also, the Diabetic Management Review exemplified a process in which regular review system wide can be integrated with individual management of a chronic condition.<br><br>The morning clinical services meeting also provided a daily process for tracking health status of individuals. Any identified significant changes in status, such as acute | Noncompliance |

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| | | conditions identified during the prior day or during overnight call, emergency room visits, hospitalizations, and important lab results, were reported to an integrated group.<br><br>Nevertheless, the following examples and issues indicate compliance has not yet been reached.<br>• Examples were reported in Provision L1 in which there was lack of follow up to medical conditions indicated in x-ray and lab studies.<br>• As reported in Provision O7, 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. Furthermore, 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).<br>• As reported in Provision M2, although completion of Section XI of the nursing assessments showed significant improvement, they did not yet consistently include the individuals' health status in relation to the identified nursing diagnoses/problems as to whether they were improving, maintaining, or regressing.<br>• As reported in Provision P1, OT/PT assessments did not include schedules of monitoring and did not consistently include analysis of the individuals' health status compared to previous years or assessments.<br>• As reported in Section F and Provision H1, timeliness of assessments was variable. The Facility had implemented an initiative to improve both timeliness and comprehensiveness of assessments so that they can be more effective in monitoring, documenting, and reporting health status of individuals.<br><br>The medical peer review audit medical management component included questions that addressed monitoring health status for several health conditions. However, this process, while useful in assessing whether monitoring of health status is occurring, was not intended to and did not itself provide monitoring of the health status of individuals. It did provide the Facility with information on whether physicians carried out appropriate monitoring for the sample of individuals reviewed.<br><br>A policy/protocol did not exist that addresses the health status monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. Such a process should include clinical indicators and should involve reporting of resolution of acute conditions and measure or improvement or decline in | |

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| | | people with chronic health conditions.<br><br>The Facility is approaching having a system in place to monitor health status of individuals. The new initiative on assessments has potential to improve this. The Facility needs to organize its use of clinical indicators, chronic care visits, reviews of specific conditions, and assessments into a coherent and organized comprehensive review for each individual, and use its medical quality assurance process to ensure all needed monitoring and follow up are done. | |
| 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. | Although DSSLC had made great gains in identifying and tracking clinical indicators and in implementing systems for monitoring chronic conditions, the Facility did not have clear guidance in policy or procedure on the use of clinical indicators or on when treatments and interventions should be modified. In the medical arena, DADS had developed, for a set of conditions, clinical pathways to provide such guidance. The Facility did not provide information on its own development of such pathways or of implementation of processes related to the DADS-developed pathways but did report that binders of clinical pathways were distributed to all clinics for physicians to use. To be most useful, such pathways must be supported by appropriate clinical indicators and guidance for how these indicators lead to decisions on treatments and interventions.<br><br>The development of clinical indicators that provide information both for decisions on care for individuals and for Facility-level planning could be used to provide a means to identify when modifications to treatments and interventions should be modified (or rationale documented for lack of modification) based on objective information.<br><br>The requirements of this provision related also clinical disciplines other than medicine. In addition to the clinical pathways and clinical indicators being developed, identification and tracking of clinical indicators are important for making decisions about a wide range of interventions.<br><br>For example, clinical indicators should provide one source of information used in assessment of risk, planning of interventions for behavioral services, and modification of PNMPs, among other clinical services. As noted in Provision H4, issues in the definition and use of clinical indicators need to be resolved in order for them to be consistently useful in determining when to modify treatments and interventions.<br><br>There were examples in which clinical indicators were used effectively to determine when treatments needed modification. For example, it was reported by the Diabetic Nurse Educator that after Individuals #210, #611, #526, #411, and #496 with type II Diabetes had their cross-reference of metformin dosages, current HgbA1c, and blood glucose trend data for 2012 reviewed by the respective physician these Individuals' had | Noncompliance |

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| | | their medication dosages either decreased or discontinue due to weight loss, glycemic control, and normalization of blood glucose trending.<br><br>There were also examples in which modifications did not occur in response to changes in clinical indicators, or in which review of indicators did not occur timely. For example:<br>• Individual #33 experienced a spike in physical aggression in May 2012. Although physical aggression rates remained elevated for several months, Facility documentation did not reflect recognition that assessments should be reviewed or that revisions to the PBSP should be considered.<br>• Individuals #691 and #175 had AAC objectives but there was no evidence of monthly or quarterly review by the SLP or QMRP. | |
| 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. | The Facility policy governing integration of clinical services, DSSLC Policy CMGMT 03 had been revised. This purpose of this policy was to "provide integrated clinical services… to ensure that individuals receive the clinical services they need." This policy provided for and described a number of procedures including membership and purpose of committees and meetings, along with brief descriptions of processes. Beyond that, the policy did not identify other processes to ensure integration of services or means to assess whether integrated planning has occurred and has resulted in integrated plans, and it did not address issues of assessments and use of clinical indicators. It did address the requirement for chronic care visits and the requirement for health management plans to be updated to reflect changes in the individual's clinical condition.<br><br>Furthermore, DADS policy remained in draft. A draft DADS state policy was available that addressed Provisions G and H together. The policy was not yet completed or disseminated. The majority of the policy addressed section H and appeared to be a good start to providing the Facility with some guidance and direction. It might be helpful to indicate how the contents of the policy related to each of the specific seven provision items of Section H. For provision item H1, the policy listed some details about the regulatory or statutory requirements for a nursing quarterly review, an annual dental exam, a review of behavior control drugs, an annual physical, and a review of risk status. There was nothing in the policy, however, regarding assessments and evaluations for psychiatry, psychology, pharmacy, physical therapy, speech and language therapy, dietary needs, occupational therapy, and respiratory therapy (in this policy, DADS added respiratory to the list of clinical services).<br><br>DADS Policy 009.1 Medical Care had been revised in September 2012. This policy addresses responsibilities of physicians regarding acute and chronic conditions, medical orders, consultations, responsibilities of the physician and pharmacist for new drug orders and drug regimen reviews, hospitalizations, infection control, vaccinations, and | Noncompliance |

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| | | documentation. It lists a small number of clinical indicators but does not clearly define what data will be collected.<br><br>The Facility Policy MED-01 Medical Care had not been revised to operationalize the revisions to DADS policy. The Medical Director reported to the Monitoring Team that the Facility continues to develop a draft policy. Therefore, a Facility policy/protocol did not exist that addresses the health status monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. The Facility should update its policy to operationalize DADS policy. To achieve compliance, both the Facility and DADS will need to ensure policies that address the requirements of this Section are established and monitored for accurate implementation. | |

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

1. As part of its initiative on assessments, the Facility should review the scoring tools to ensure they monitor definition and review of clinical indicators to be monitored for individuals. (Provisions H1 and H4)
2. Once the initiative on assessments completes effective action on timeliness and comprehensiveness of annual assessments, develop a process to ensure clinical indicators and other information lead to timely modification of treatments and interventions. (Provision H6)
3. Develop a process to assess whether all assessment documentation is provided to support diagnoses, including providing rationales for diagnoses, and to ensure that diagnoses match information from diagnostic testing or rationales for not listing such diagnoses are documented. (Provision H2)
4. Expand on and localize implementation procedures for the clinical pathways developed by DADS and ensure they are supported by appropriate clinical indicators and guidance for how these indicators lead to decisions on treatments and interventions. (Policy H6)
5. DADS should complete and implement policy on minimum common elements of clinical care. This policy should address all areas of clinical care. (Provision H7)
6. The Facility should update its medical care policy to operationalize DADS policy. (Provision H7)

| SECTION I: At-Risk Individuals | |
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| 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:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment 9/24/12<br>2. DSSLC Action Plan 9/24/12<br>3. Section I Presentation Book (undated)<br>4. DADS Policy 006.1 At Risk Individuals 2/18/11<br>5. DSSLC Policy CMGMT -14 At Risk Individuals 3/25/12<br>6. Minutes for the PNMT and Physical and Nutritional Management Committee (PNMC) meetings for the past 6 months<br>7. List of Health Risk Ratings for each risk factor/individual (undated)<br>8. Record reviews for Individuals #19, #90, #134, #175, #192, #243, #255, #279, #298, #299, #386, #432, #466, #587, #606, #622, #633, and #715 (sample selected for data analysis)<br>9. Integrated Risk Rating Form and Risk Action Plan for Individuals #19, #123, #152, #192, #231, #262, #298, #438, #622, #633, and #715<br>10. Section O – Sample #2<br>11. List of Top 10 individuals causing injury to peers<br>12. List of Top 10 injured individuals.<br>13. List of individuals supported with bedrails<br>14. List of individuals injured from bedrails<br>**People Interviewed:**<br>1. Nancy Condon, Facility Director<br>2. Donna Groves, OTR, Director of Habilitation Services<br>3. Cecilia Payne COTA PNMP Coordinator<br>4. Erin O'Toole SLP<br>**Meetings Attended/Observations:**<br>1. Physical and Nutritional Management Team 10/9/12<br>2. ISP meetings for Individuals #250 and #750 |
| | **Facility Self-Assessment:**<br>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 risk data by home, and a review of high risk categories. A key requirement of this Section of the SA is that the Facility has a "regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk." The self-assessment did not apparently review and assess the Facility processes and system to ensure this key requirement of the SA was addressed. Similarly, the Action Plan which accompanied the self-assessment did not address this important requirement particularly in the context of an overall management system which guides the risk assessment/action plan process.<br><br>Based on the findings from its self-assessment, the Facility determined that it was not in substantial compliance because the reliability of risk assessments and ratings was not always determined to be reliable. |

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| | The Facility reported that actions described at the last review to increase data collected and address inter-rater reliability had led to improvement, and recent inter-rater reliability was approximately 90%. The Facility also reported that risk action plans often did not include clinical indicators to be monitored and/or the frequency of such monitoring.<br><br>The Monitoring Team's review findings were consistent with this self-assessment. |
| | **Summary of Monitor's Assessment:**<br>The statewide risk assessment policy, with guidelines for rating risk, was in use at the Facility. The Facility continued to use supplementary tools that helped IDTs in the risk assessment planning process.<br><br>The Facility did not have a local policy and procedure which defined operational practices necessary to demonstrate that a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk is in place as required by the SA.<br><br>The Facility continued to have a very active Physical and Nutritional Management Committee. It was evident to the Monitoring Team that the work of this committee was substantive and oriented to decision-making. The committee members were the key players needed to effectively implement the policies and procedures necessary to achieve compliance with this Provision of the SA.<br><br>The Monitoring Team observed two ISP meetings held during the week of the review. Participation by relevant staff and use of clinical data in reviewing risk was variable.<br><br>The risk assessment process in place at the Facility did not always accurately assess risk and consider discipline specific clinical information when reviewing risk. Few risk ratings adequately rated the individuals on all risk categories based on supporting clinical data.<br><br>As noted in previous reports, there remain issues with interdisciplinary clinical coordination.<br><br>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. |

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| I1 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>• Review of policy to see if it included information required by the settlement | Noncompliance |

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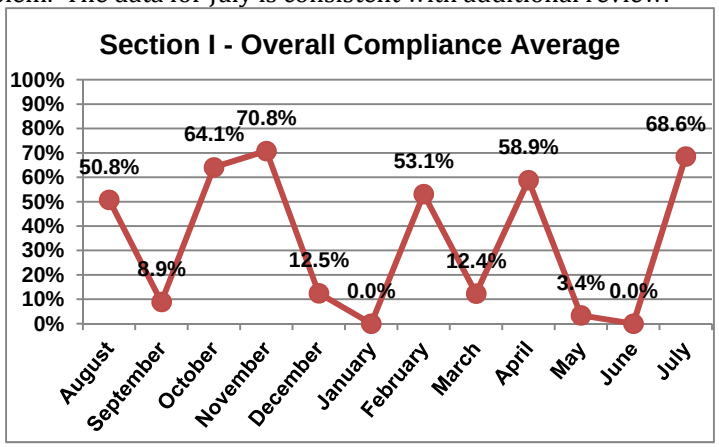
| | implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk. | agreement.<br>• Review of overall risk data by home and compare to home population rosters to determine if all individuals have had a risk assessment completed.<br>• 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.<br>• Review of Monitoring for Section I to determine current monthly compliance percentages.<br><br>From its self-assessment the Facility determined that:<br>• The policy does include a risk screening, assessment and management system. There is a draft revised state policy related to new risk system but it has yet to be finalized.<br>• All individuals currently have risk ratings completed by their interdisciplinary teams.<br>• A list of those at high and medium risk was pulled for Aspiration, Choking, Respiratory Compromise and Challenging Behavior. Review of these lists indicated improvement in our ratings of individuals. These improvements include that on the lists six people were on the list for choking that had choking incidents. This is compared to one person a year ago. The lists for risk of aspiration also appeared to be more accurate since the number listed as high risk had increased significantly (23 – 73). A sample of those with incidents of aspiration during 2012 was reviewed and all but one or 94.2% were on the list.<br>• Section I monitoring data was still problematic but additional Inter-rater reliability (IRR) activity during this six months appears to have corrected this problem. The data for July is consistent with additional review.<br>  <br> | |

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| | | Based on the findings from this self-assessment, this provision is not in substantial compliance because success is at 68.6% and there is change in the process that has not been implemented center wide. Once given authorization to implement center-wide we will need to analyze the data under the new system and ensure implementation is complete.<br>• Review of policy to see if it included information required by the settlement agreement.<br>• Review of overall risk data by home and compare to home population rosters to determine if all individuals have had a risk assessment completed.<br>• 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.<br>• Review of Monitoring for Section I to determine current monthly compliance percentages.<br>• Selection and review of additional sample for self-assessment purposes.<br><br><u>Monitoring Team Findings:</u><br>As was noted in its the last report the Monitoring Team was able to validate that the statewide risk assessment policy, with guidelines for rating risk, was in use at the Facility. The Facility continued to use supplementary tools that IDTs could use in the risk assessment planning process.<br><br>A key requirement of this Section of the SA is that the Facility has a "regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk." The Facility did not to present a clear articulation of such a system either in its self-assessment or presentation book. As reported in the self-assessment, there is a draft revised state policy related to new risk system but it has yet to be finalized. While the Monitoring Team believes many of the components of a management system to identify individuals whose health or well-being is at risk were in place it was not possible to validate that all components were in place in an interdisciplinary and integrated manner. As noted in previous reports, there remain issues with interdisciplinary clinical coordination.<br><br>The Facility continued to have a very active Physical and Nutritional Management Committee. This group meets 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. It was evident to the Monitoring Team that the work of this committee was substantive and oriented to decision-making. The committee members were the key players needed to effectively implement the policies and procedures necessary to achieve compliance with this | |

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| | | Provision of the SA. The Monitoring Team remains optimistic that the work of this committee will lead to significant improvement in risk assessment in future reviews.<br><br>Other examples of processes that hold promise of improving assessment and addressing of risk include:<br>• The Hospital Liaison Nurses routinely attended Infirmary Morning Meetings 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 and when discharge was planned. 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.<br>• The Diabetic Nurse Educator was working collaboratively with the IDTs and Pharmacist to identify early, individuals who may be at risk for metabolic syndrome.<br><br>The Monitoring Team observed two 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 #750 did not include staff from the dental department even though this individual had related service needs. The individual was present at both meetings, although Individual #750 had to leave early because of a seizure.<br><br>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, in only one (Individual #250) did the IDT use clinical data (which was also available in the other meeting) in determining risk levels and developing rationale for these determinations. Refer to Provision V.4 for additional information.<br><br>Neither IDT engaged in substantive discussion on how risk impacted potential alternative placement in a more integrated setting.<br><br>In both meetings the ISP facilitator kept the team discussion focused.<br><br>The risk assessment process in place at the Facility did not always accurately assess risk. For example, based on a review of 11 (Sample 0-#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 | |

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| | | nutritional decline. Examples of individuals not being appropriately identified include:<br>• Individuals #42 and #119 were identified as being at a "medium risk" of aspiration but per risk guidelines should have been listed as a "high risk" due to recent aspiration events.<br>• Individuals #255 and #534 were identified as being at a "medium risk" of choking but per risk guidelines should have been listed as a "high risk" due to recent choking events.<br>The IDT had the ability to lower the risk; however, there was no evidence of the rationale behind the lower risk score.<br><br>Other examples of lack of accurate rating and management of risk included:<br>• For Individual #596, the annual ISP dated 4/24/12, did not indicate degenerative spine disease as a serious risk.<br>• The pharmacist documented that Individual #119 had diabetes, hyperlipidemia, and an enlarged waist circumference and stated "MS criteria met" (metabolic syndrome); however, there was no recommendation made regarding this issue, the ISP did not reflect this serious risk, and the medication review form did not indicate such as risk.<br>• Individual #90 was prescribed two neuroleptics, and had diagnoses of diabetes, hypertension, and hyperlipidemia. The QDRR did not indicate that the individual had metabolic syndrome, and the ISP did not document review of risk versus benefits.<br>• Six of 11 (55%) acute care plans reviewed included adequate proactive/preventative measures to reduce and/or eliminate risk indicators/problems.<br><br>The Facility's regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk should include regular evaluations of the need for continued use of bedrails for each specific individual, whether alternative devices might be safer, and that in instances where bedrail use is determined to be necessary that the Facility initiate a routine surveillance program. A routine surveillance program should ensure bedrails are in good working order, entrapment and elopement opportunities are mitigated, and staff are trained in specific observation techniques that are necessary when providing supervision to each specific Individual who is in a bed with a bedrail or any other device designed to prevent accidental injury. During this review the Monitoring Team discovered many instances of unsafe bedrails for which the Facility responded by initiating an immediate comprehensive inspection followed by corrective actions as warranted.<br><br>The Monitoring Team concurs with the Facility self-assessment that it is not in | |

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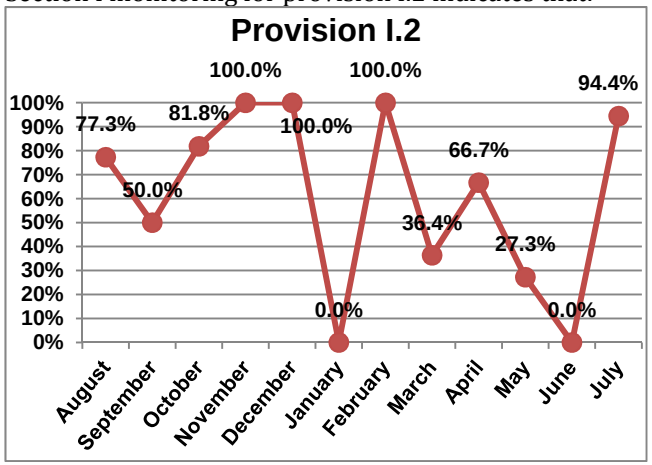
| | | substantial compliance with this Provision of the SA. | |
| I2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk 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><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Review of Denton State Supported Living Center inter-rater reliability for Section I monitoring tool.<br>2. Review of Monitoring for provision I.2 to determine current monthly compliance percentages.<br>3. Review of additional sample.<br><br>From its self-assessment the Facility determined that:<br>1. Inter-rater reliability check found problems with inter-rater reliability. Additional work was undertaken to correct this problem. Reliability has increased to 89% for one auditor and 93% for the other which is within the acceptable range.<br>2. Section I monitoring for provision I.2 indicates that:<br>  <br><br>The months that were zero were due to a document that the auditor did not locate and thus all areas scored "no". This problem was corrected.<br>3. Due to 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. There was improvement in this occurring within 5 days of the change in status from 67% last monitoring visit to 83% this visit.<br><br>Based on the findings from this self-assessment, this provision is not in substantial | Noncompliance |

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| | | compliance because significant variances in monitoring data continued into this time period. Additional time is needed to ensure improvement in reliability maintains. Additional review of records indicated that IDTs are failing to implement reassessment within 5 working days of a status change 27% of the time.<br>• Review of Denton State Supported Living Center monitoring tool data for Section I.2.<br>• Selection and review of additional sample for self-assessment purposes.<br><br>Monitoring Team note: The Facility's Section I Presentation Book did not include any material labeled as documentation to support compliance activity related to Provision I.2.<br><br><u>Monitoring Team Findings:</u><br>The Monitoring Team selected 18 records to review to assess compliance with this provision. These were for Individuals #19, #90, #134, #175, #192, #243, #255, #279, #298, #299, #386, #432, #466, #587, #606, #622, #633, and #715. The most recent risk assessment for these 18 individuals reported a change in status in only five cases. These were for Individuals #715, #243, #134, #279, and #432. In two of these five (40%) the assessment process started within five days. In the other 13 cases a comprehensive assessment that could have determined whether or not a change in status was appropriate only occurred with three individuals (23%). This was the case with Individuals #298, #622, and #633.<br><br>Based on a review of nursing risk assessment records of a sample of six of these individuals (Individuals #19, #192, #175, #298, #622, and #633), three (50%) included an adequate nursing assessment to assist the team in developing an appropriate plan. This was the case for Individuals #298, #622, and #633. The following provides an example of an assessment that was not comprehensive: Individual #19 had a medium risk for constipation and bowel obstruction. Clinical data was not integrated and only provided a list of prescribed laxatives. The assessment did not include bowel elimination patterns, or other clinical data, including history of impaction and/or bowel obstruction or other alternatives tried to prevent or reduce the need for multiple laxatives. Refer to Section M.5 of this report for additional information on issues related to nursing risk assessments.<br><br>Based on a review of PNMT records of a sample of six of these individuals (Individuals #715, #466, #243, #134, #279, and #432) for whom assessments had been completed to address the individuals' at risk conditions, only one (100%) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in developing an appropriate plan. This was the case for Individual #715. His risk assessment was modified to reflect high risk for pneumonia. The IDT reviewed head of | |

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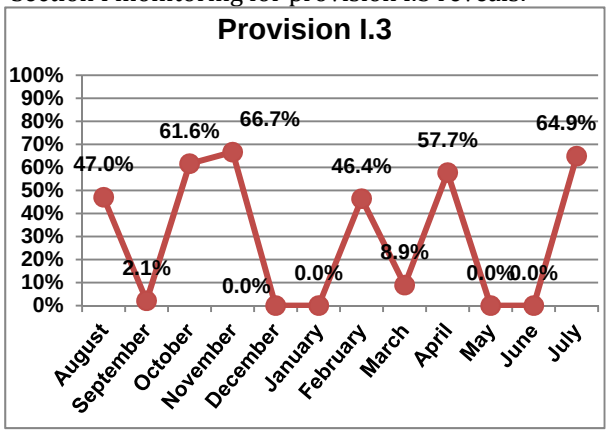
| | | bed recommendations and had collaborative meetings with the PNMT to discuss the course of actions necessary to manage the risk. An example of an inadequate risk assessment was Individual #134 who was diagnosed with aspiration pneumonia on 5/17/12 and returned to the Facility from the hospital on 6/13/12. There was no evidence that the IDT reviewed the circumstances of her hospitalization in the context of risk assessment and planning. Refer to Sections O and P of this report for additional information.<br><br>Based on a review of risk records of six individuals (Individuals #587, #90, #606, #386, #299, and #255) 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. Refer to Section J of this report for additional information<br><br>The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this Provision of the SA. | |
| I3 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring. | <u>Facility Self-Assessment:</u><br>The Facility engaged in the following activities in conducting its self-assessment of this Provision:<br>1. Review of Denton State Supported Living Center Monitoring/Tool data for provision I.3.<br>2. Selection and review of additional sample for self-assessment purposes.<br><br>From its self-assessment the Facility determined that:<br>1. Section I monitoring for provision I.3 reveals:<br>  <br><br>The data obviously shows great variation. Efforts to improve inter-rater | Noncompliance |

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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reliability did not prove to be effective. Additional efforts do appear to have fixed this problem but it is too soon to tell.<br>
2. Due to the small number of tools used and the variation, an additional sample of risk documentation for six individuals with changes in status was pulled. This data showed the following:
<table>
<tr><td>Item</td><td>March 2012</td><td>August 2012</td></tr>
<tr><td>Actions developed by the team -100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Actions implemented within 14 days of plans finalization</td><td>83%</td><td>100%</td></tr>
<tr><td>Actions include clinical indicators to be monitored</td><td>50%</td><td>67%</td></tr>
<tr><td>Actions include frequency of monitoring</td><td>67%</td><td>50%</td></tr>
</table>
Based on the findings from this self-assessment, this provision is not in substantial compliance because significant variances in monitoring data continued into this review period and action plans need to include additional information.<br>
• Review of Denton State Supported Living Center Monitoring/Tool data for provision I.3.<br>
• Selection and review of additional sample for self-assessment purposes.<br><br>
Monitoring Team note: The Facility's Section I Presentation Book did not include any material labeled as documentation to support compliance activity related to Provision I.3.<br><br>
<u>Monitoring Team Findings:</u><br>
Based on a review of 18 records for individuals determined to be at risk there was documentation that the Facility:<br>
• Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate in one (6%)) case. This was the case for Individual #715.<br>
• Implemented a plan that met the needs identified by the IDT assessment in one (6%) case. This was the case for Individual #715.<br>
• Included preventative interventions in the plan to minimize the condition of risk in two (11%) cases. This was the case for Individuals #633 and #715.<br>
• When the risk to the individual warranted (one case), the Facility took immediate action. This was the case for Individual #715.<br>
• Integrated the plans into the ISPs in one (6%) case. This was the case for Individual #715.
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| | | • In two (11%), the risk plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. This was the case for Individuals #192 and #715.<br>• In one (6%), 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 for Individual #715.<br>• One (6%) included the clinical indicators to be monitored and the frequency of monitoring. This was the case for Individual #715.<br><br>The Monitoring Team identified one risk action plan (Individual #243) that was sufficiently detailed that if followed would likely be effective in managing or mitigating risk.<br><br>The Monitoring Team concurs with the Facility self-assessment that it is not in substantial compliance with this Provision of the SA. | |

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

1. Establish local policy and procedure that defines operational practices necessary to demonstrate that a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk is in place as required by the SA (Provision I.1).
2. 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)
3. 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)
4. 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)
5. 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 | |
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| 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:**<br>**Documents Reviewed:**<br>1. DSSLC Self Assessment (09/24/12) and Action Plans (09/24/12)<br>2. Facility Presentation Book for Section J (undated)<br>3. DADS Policy and Procedures 007.2 Psychiatry Services (08/30/11)<br>4. DADS Policy and Procedures 007.3 Psychiatry Services (draft)<br>5. DADS Procedure 001.1 Use of Restraints (04/10/2012)<br>6. DADS Nursing Protocol Post Anesthesia Care (06/2010)<br>7. DADS Nursing Protocol Pre-treatment and Post Sedation Monitoring (06/2010)<br>8. DADS Medical/Dental Restraint Checklist (04/ 2012)<br>9. DSSLC Policy and Procedure CMGMT-21 on Dental and Medical Restraint (11/05/09)<br>10. DSSLC Procedure: Desensitization CMGMT 24 (12/15/11)<br>11. DSSLC Nursing Responsibility related to restraints (updated 02/16/12)<br>12. DSSLC Policy Med-10 Psychiatry Services (01/15/11)<br>13. DSSLC Pharmacy Policy #47 Pharmacy Metabolic Syndrome Risk Monitoring Policy (revised 09/15/12)<br>14. DSSLC Nursing Services In-service Training Summer 2012: Instructions for completion of sedation process.<br>15. 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<br>16. 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)<br>17. Minutes of the Pharmacy and Therapeutics Committee (P&TC) and the Polypharmacy Review Committee (PRC), since the last compliance visit<br>18. A list of individuals prescribed intraclass polypharmacy and interclass polypharmacy, including the names of medications prescribed and each medication's start date<br>19. A tabulation that compared rates of Facility use of polypharmacy over the period from January 2010 until the present<br>20. A separate list of individuals for whom each of the following is prescribed:<br>a. Anticonvulsant medications being used only for psychiatric indications<br>b. Anticonvulsant medications being used only for neurological indications<br>c. Anticonvulsant medications being used for both neurological and psychiatric indications<br>d. Lithium<br>e. Tricyclic antidepressants<br>f. Trazodone<br>g. Beta blockers being used as a psychotropic medication<br>h. Clozaril/Clozapine |

i. Mellaril
j. Reglan
k. Anticholinergic medications
l. Benzodiazepines

21. A list of individuals who had medical support plans and dental support plans to reduce the need for pre-treatment sedation
22. The number and percentage of individuals who had dental procedures, who also received pre-treatment sedation (Total Intravenous Anesthesia (TIVA) or oral)
23. A list of all individuals screened for tardive dyskinesia with Dyskinesia Identification System Condensed User manual (DISCUS) evaluations
24. DISCUS forms done over the past year that were rated "5" or higher
25. A list of all individuals diagnosed with tardive dyskinesia
26. A list of all individuals screened with Monitoring of Side Effect Scale (MOSES) side effects evaluations
27. A list of individuals diagnosed with tardive dyskinesia and the Active Problem Lists (APL) for each of those individuals
28. Reiss screens (both data and scoring sheets) done since the last review
29. A list of all individuals whose scores matched or exceeded Reiss Screen cut-off values per instrument guidelines
30. Description from DSSLC of the kinds of procedures considered routine care and kinds of procedures considered to be non-routine (undated)
31. Individual Support Team (ISP) materials presented by the Interdisciplinary Team (IDT) for ISP meeting on 12/12/12 for Individual #250
32. Sample J1: Materials presented to the treating psychiatrists for Psychiatric Medication Review (PMR) clinics on 10/08/12 and 10/09/12. Individuals #133, #271, #336, #472, and #703 were reviewed.
33. Sample J2: Case reviews for individuals that included individuals considered by the Facility to be stable on their current psychotropic medication, individuals who had with complex pharmacological regimens, and an individual who had an ISP during the visit. These were individuals #28, #127, #182, #216, #217, #230, #250, #255, #271, #349, #482, #606, #612, #622, #673. 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 (PBSP) 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 Monitoring of Side Effects Scale (MOSES) and dyskinesia identification system (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

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| | behaviors –copies of the plan to reduce risk (ISP addenda)<br>m. Medical and/or dental plans to increase cooperation/participation and reduce the need for pre-treatment sedation<br>n. Most recent Annual Nursing Summary<br>o. Most recent Neurology Consultation<br>34. Sample J3: Episodes of medical restraint for Individuals#90 (06/29/12), #123 (06/26/12), #37 (07/09/12), #684 (08/23/12), #196 (07/23/12), #474 (06/20/12), #171 (05/09/12), # 183 (05/14/12) and # 345 (08/23/12). Each episode was reviewed for 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). Each episode was also reviewed for plans to minimize the need to use medical restraint: Materials reviewed included 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<br>35. Sample J4: Annual Psychiatric Evaluations for Individuals #61 #371, and #397, all of whom who had changes in diagnosis six to twelve month prior to the visit<br>36. Sample J5: 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: #67 (Seroquel), #68 (Remeron), #198 (Zyprexa), #217 (Abilify), #222( Remeron), #259 (Atarax), #273 (Klonopin, Depakote, Seroquel), #373 (Lunesta), #449 (Klonopin), #492 Namenda, #534 (Namenda), #606 (Tegretol), #638 (Wellbutrin), #684 (Trazodone), #686 (Ativan), #702 (Namenda, Seroquel), #753 (Seroquel) and #788 (Remeron). Materials reviewed included: Information from the clinical record (e.g. progress notes, psychiatrists' Medication Plans (MPs), psychiatric treatment reviews, ISPAs) that helped the Monitoring Team understand the reasons/clinical rationales for choice of the medication, Consent for use of the Psychotropic Medication signed by the legally authorized individual (LAR), Revised PBSP<br>37. Sample J6: Documents related to psychiatric and neurological care for five individuals who took anticonvulsant medications for both neurological and psychiatric indications. Individuals #60, #255, #277, #319, and #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.<br>38. Sample J7: 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 #90, #255, #299, #386, #587, and #606. Materials reviewed included:<br>a. The most recent Risk Assessment and the results of the previous Risk Assessment<br>b. The individual's ISP prior to the most recent risk assessment and/or any ISP change of status documentation<br>c. Documentation of assessments and other steps taken to develop an action plan to reduce the risk<br>d. The action plan to address the risks (either ISPA or new ISP) |

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| | **People Interviewed:**<br>1. Ranganath Habbu, MD, Staff Psychiatrist<br>2. Arifa Salam, MD, Lead Psychiatrist<br>4. Satyajit Satpathy, MD, Staff Psychiatrist<br>5. Randy Spence, BCBA, Director of Behavioral Services<br>5. Jill Wooten, BCBA, SA Section C Lead<br>6. Delia Schilder, RN, Chief Nurse Executive (CNE)<br>7. Sibylle Graviett,, RN, Nurse Case Manager Supervisor<br>**Meeting Attended/Observations:**<br>1. PMR clinic with Dr. Salam, 10/08/12<br>2. PMR clinic with Dr. Habbu, 10/08/12<br>3. PMR clinic with Dr. Satpathy, 10/08/12<br>4. Polypharmacy Review Committee 10/09/12<br>5. P&TC 10/09/12<br>6. Meeting on 10/09/12 with Ms. Wooten, Ms. Karen Bishop, and Dr. Eric Wear, regarding medical restraints<br>7. Meetings on 10/09/12 with Ms. Schilder and Ms. Graviett regarding medical restraints<br>8. ISP Annual Planning Meeting for Individual #250 on 10/10/12 |
| | **Facility Self-Assessment:**<br>DSSLC presented a self-assessment, authored by the Lead Psychiatrist. The Facility described, for each provision item, the activities the Facility engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating for the provision item. The self-assessment was followed by Action Plans that described how the Facility planned to bring each provision item into substantial compliance or, where applicable, to maintain compliance already achieved. For each provision item the document listed the action step, evidence, person responsible for the action, start date, projected completion date, and completion status.<br><br>In the self-assessment, the Lead Psychiatrist acknowledged that a formal QA audit for psychiatry had not occurred, due to a lack of resources to complete such an audit. The self-assessment reported on the activities that had taken place. These were:<br>1. Review of psychiatric evaluations of six individuals newly referred to the psychiatry clinic.<br>2. Review of seven of one hundred and five annual psychiatric summaries done since April 2012.<br>3. Informal review of a sample of records of individuals who received psychiatric care and services, including PBSPs, Comprehensive Psychiatric Evaluations (CPEs), Psychiatric Medication Reviews (PMRs), and tracking of psychiatric symptom data.<br>4. Review of the Facility's data for use of chemical restraints.<br>5. Review of pharmacy data for trends in psychotropic medication use at the Facility.<br>8. Review of monthly Review of monthly restraint audit compliance results for the months of April, 2012 through July, 2012.<br>9. Review of the Facility Restraint Trends analysis report for the months of April, 2012 and May, 2012. |

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| | 10. Review of the Facility Quarterly Quality Assurance /Quality Improvement (QA/QI) data for restraint.<br>11. Review of the current list of individuals in need of treatments, strategies, or supports to reduce the need of restraint, which includes listing of completion status of treatments, strategies, and supports.<br>12. Review information from the Facility Director indicating if any individuals living at the Facility have restrictions or prohibitions for restraint.<br>13. Review of Restraint Reduction Committee meeting minutes from April, 2012 through August, 2012. Review of current training curricula for Restraint Review of responsibilities of psychiatrists at DSSLC, to include clinical and administrative responsibilities, and required attendance at various meetings.<br>14. Review of the documents establishing licensure and board certification status of the psychiatrists. Monthly review of a random sample of Reiss Screens of ten individuals who are currently not provided services by psychiatry department.<br>15. Record review of all the individuals who received a positive score on their Reiss Screens. Psychiatrist participation and sharing of psychiatric information at ISP meetings was reviewed. Review of DSSLC monthly polypharmacy meeting process and meeting minutes to evaluate compliance with this provision. Documents reviewed included minutes for meetings held each month between April, 2012 and August, 2012.<br>16. Review of DSSLC psychiatry department database for completion of MOSES and DISCUS for psychotropic medications by nurse case managers at quarterly meetings.<br>17. Review of DSSLC psychiatry department database for tracking Tardive Dyskinesia diagnosis.<br>18. Review of the process for implementation of Facility wide system for tracking of MOSES and DISCUS for psychotropic and non-psychotropic medications.<br>19. Review of IC forms and Psychotropic MPs for 20 new non-emergency psychotropic medications started since April, 2012.<br>20. Review of PBSPs with addendum/update for the 20 new non-emergency psychotropic medications prescribed since April, 2012.<br>21. Review of monthly meeting minutes to evaluate the process of coordination between Psychiatry and Neurology regarding the use of dual purpose medications for seizure and psychiatric management.<br><br>During the visit, a member of the Monitoring Team met with the Lead Psychiatrist and reviewed the results of the Facility's Self Assessment and the Action Plans that followed. The discussion was also guided by the evidence book that the Facility prepared for the visit that included materials referred to in the Self Assessment. The discussion reviewed each provision item separately, followed by a general discussion of the overall status of the Facility's efforts to meet the requirements of the Settlement Agreement (SA). The meeting took place on the first day of the visit, so that both the Facility and the Monitoring Team could use on-site time in the best way possible.<br><br>There were only two provision items where the Facility rated differently than the Monitoring Team. On provision item J7 the Facility self-rated for substantial compliance but that was made before the Facility |

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| | decision to revisit REISS screens for individuals who live at the Facility. For provision J10 the Monitoring Team found that more work was needed regarding treatment alternatives.<br><br>During the visit the Monitoring Team and the Facility discussed how to best use both internal QA and the self assessment process. The internal auditing process will be best supported by use of the statewide DADS audit tool, Facility-specific responses to the comments of the Monitoring Team for particular provision items, and by review of clinical indicators for good psychiatric practices. |
| | **Summary of Monitor's Assessment: Summary of Monitor's Assessment:**<br>Progress was noted in a number of areas. Improvements in integrated care were noted via interdisciplinary work at the Polypharmacy Committee and in the Neurology Clinic. There has been a fair amount of work done to develop needed details for MPs and to implement monitoring procedures to assess medication efficacy. There have been some setbacks in completing requirements for deployment of Reiss Screens across the campus, but the Facility has developed a reasonable plan to respond to the setbacks.<br><br>Comments on specific provisions follow:<br><br>**For Provision J1:** The provision remained in substantial compliance: The Facility continued to employ three full time staff psychiatrists and two part time contract psychiatrists. All were board certified or board eligible in psychiatry. The psychiatrists actively and appropriately participated in the interdisciplinary process.<br><br>**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.<br><br>**For Provision J3:** The provision was determined to be not in compliance. Continued improvements were noted in the presentation of psychiatric information in the PBSP that helped clarify how medications were used as part of the overall treatment program. Further work is needed in the area of presentation of psychiatric data.<br><br>**For Provision J4:** The provision was determined to be not in compliance. The new procedures for medical/dental restraint were not yet fully in place. Reductions were noted in the amount of pre-treatment sedation that was used, but work remains to be done in the area of individualized action plans to help individuals participate in routine procedures without need for sedation.<br><br>**For Provision J5:** The provision remained in substantial compliance. Psychiatrists at the Facility had heavy clinical caseloads, and the workload was increased by Dr. Harden's absence. Nonetheless they were able to provide the services required by the SA.<br><br>**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. Improvements were also needed in the area of case |

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| | formulations.<br><br>**For Provision J7:** The provision was determined to be not in substantial compliance. The Facility has identified the need to re-administer the Reiss Screen to individuals who do not have comprehensive psychiatric evaluations in place.<br><br>**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.<br><br>**For Provision J9:** The provision was determined to be not in compliance. The provision is not in compliance due to the need to better address which modality or modalities of treatment are the best clinical choice to address the problem at hand.<br><br>**For Provision J10:** The provision was determined to be not in substantial compliance. The provision is not now in substantial compliance due to a need to improve the presentation of both the risk/benefit analysis and the discussion of treatment alternatives.<br><br>**For Provision J11:** The provision was determined to be in substantial compliance. Reductions in unnecessary polypharmacy continue, and the PRC continues to support good interdisciplinary discussion on many aspects of overall pharmacological care.<br><br>**For Provision J12:** The provision was determined to be not in substantial compliance. Use of side effect screens had improved, but procedures were not yet in place for change of status evaluations.<br><br>**For Provision J13:** The provision was determined to be not in substantial compliance. Improvements were noted in the MPs. MPs need more details in the areas of treatment alternatives and risk benefit analysis.<br><br>**For Provision J14:** The provision was determined to be not in substantial compliance. Adequate presentation of treatment alternatives were not yet in place and many consents for new medication were not fully reviewed by the HRC since revised PBSPs had not been completed.<br><br>**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. |

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| J1 | Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified | The Facility continued to employ Drs. Ranganath Habbu, Arifa Salam and Satyajit Satpathy as full time staff psychiatrists. Dr. Salam was the Lead Psychiatrist for the Facility. Dr. Harden continued to be employed as a contract psychiatrist and was on | Substantial Compliance |

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| | professionals. | medical leave at the time of the compliance tour. To assist with chart audits and related QA during his absence, the Facility hired Dr. Howard Lagrone. Dr. Lagrone had just started his work at the time of the compliance visit. Dr. Lagrone is a 1982 graduate of the University of Texas Medical School at Galveston and he completed his residency in psychiatry at that location in 1986. He received his board certification in psychiatry in 1993.<br><br>All psychiatrists had current licensure in the State of Texas. Drs. Harden, Lagrone, Salam and Satpathy were Board Certified in Psychiatry, and Dr. Habbu was Board Eligible. The psychiatrists' credentials all met the requirements of the SA.<br><br>During the tour the Monitoring Team observed the work of each of the staff psychiatrists during their psychiatric clinics, during the infirmary morning meeting, and during the polypharmacy monthly meeting. The Monitoring Team attended an ISP of an individual who received support from the Lead Psychiatrist, and observed her work during that meeting.<br><br>The Monitoring Team found that the psychiatric staff at DSSLC consisted of qualified professionals, who participated meaningfully in the interdisciplinary process. | |
| J2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist. | <u>The process in place for psychiatric evaluation and diagnosis:</u><br>The Monitoring Team observed the psychiatrists' day-to-day work in the various settings and meetings where individuals were seen and their care discussed. Psychiatrists at the Facility all conducted scheduled monthly meetings with individuals in the psychiatry clinic. These meetings were known at the Facility as PMRs. The general format for these meetings was that the nurse case manager presented information on physical health and side effect screens MOSES and DISCUS. The psychologist presented behavioral data, Direct Support Professionals (DSPs) presented information from the home, and a general discussion followed. Reviews lasted about 30 minutes, sometimes longer. Formal reviews of the diagnosis were done quarterly.<br><br>In each of the clinics observed by the Monitoring Team, there were clinical discussions that contributed to the diagnostic understanding of the individual under review. For example:<br>• For Individual #133 the IDT reviewed the symptoms that were the basis of the diagnosis of Attention Deficit Disorder. Specific monitoring was for impulsivity, irritability and insomnia. The individual had recently been tapered off a psychotropic medication (lithium) that could have an effect on these symptoms and these were carefully reviewed in reference to both his progress and the underlying diagnosis. In her mental status examination the psychiatrist reviewed the individual's status on these core symptoms. The appointment for this individual was a quarterly review, and the psychiatrist indicated in the | Substantial Compliance |

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| | | quarterly review form that the diagnosis that was in place would be continued.<br>• Individual #472 was diagnosed with Bipolar Disorder and ADHD. The symptoms of the latter were reviewed during the PTR in reference to the diagnosis. The psychiatrist noted and documented the individual's state in regard to hyperactivity and impulsivity, and commented on the use of Strattera, a psychotropic medication that is used for ADHD. The psychiatrist also commented on the individual's mood status and symptoms that were related to the diagnosis of Bipolar Disorder. There was also discussion about the diagnosis of epilepsy.<br>• Individual #271 was diagnosed with Intermittent Explosive Disorder. Data was collected on a measure of the individual's impatience and irritability that assessed behavioral characteristics of that disorder. The psychologist commented that although target behaviors had shown recent elevations, the individual's psychiatric data had remained stable. The behavioral characteristics that were measured were consistent with the psychiatric diagnosis. There was also discussion of Axis III diagnoses (epilepsy) which had behavioral symptoms.<br><br>On 10/10/12 the Monitoring Team also observed the ISP for Individual #250. The individual was diagnosed with Cornelia de Lange syndrome, a developmental disorder with a well-described behavioral phenotype. The Individual had many of the characteristics of the phenotype, and the psychiatrist's comments during the ISP reflected a good appreciation of how the treatment plan for the individual needed to include guidance that was based on that knowledge.<br><br>Overall, the observation of the psychiatrists' daily clinical process reflected that the process of diagnostic assessment and re-assessment were well incorporated in the process of the scheduled psychiatric reviews in the PMR and ISP meetings.<br><br><u>Resolution of NOS diagnoses:</u><br>The Monitoring Team reviewed the department database for diagnoses for individuals followed by psychiatry. Only 5 of 239 (2%) of individuals had NOS diagnoses. That reflected a resolution of many of such diagnoses.<br><br><u>Adequacy of the process to track diagnoses and diagnostic updates:</u> During the visit, the Monitoring Team reviewed the records of the 15 individuals in Sample J2. In all cases, the APLs that were part of the Annual Medical Evaluation contained up-to-date psychiatric diagnoses in the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) IV format.<br><br><u>Timeliness of psychiatric evaluations for new admissions:</u> One individual was admitted to the Facility during the review period. This was Individual #273, admitted on 05/30/12. The individual had a CPE 06/07/12. The CPE was done in a timely manner. | |

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| | | In summary, the Monitoring Team found that there was a good clinical process in place to provide and update CPEs for all individuals who needed them, that a good system was in place to track the diagnoses of individuals, and that client records documented accurately the up-to-date diagnoses in the required DSM format. Further information on CPEs is provided under Provision J6. | |
| J3 | Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment. | <u>PBSP documentation:</u><br>Psychotropic medications were given to 239 of the 492 (48%) individuals who lived at the Facility. The key requirement of the provision was that such medications should not be used as a substitute for a (behavioral) treatment program. To verify that the needed treatment programs were in place, the Monitoring Team compared the list of individuals who took psychotropic medications with the list of individuals who had PBSPs. The lists indicated that all individuals who needed PBSPs had them.<br><br>DAD's psychology regulations and SA Provision J13 outlined the key information about medications that needed to be in place. Previous reports of the Monitoring Team noted that required medication information was often outdated, incorrect, or missing. In addition it was often not clear why the medication was prescribed or how they related to the psychiatric disorder with which the individual was diagnosed. This was problematic, as it was sometimes not possible to tell whether medications were used to treat a psychiatric disorder or for behavioral control.<br><br>PBSP presentation of information about medication has now improved. Key information about medications and their use is copied electronically from the psychiatrist's MP and inserted into the PBSP. That was efficient use of technology, and it reduced the likelihood of errors.<br><br>The Monitoring Team reviewed the records of the 15 individuals in Sample J2. Twelve of 15 (80%) of individuals had PBSPs in the current format that included data. The exceptions were Individual #182, for whom the PBSP was not provided (although from the list of PBSPs it was clear that he had one); Individual #612, for whom the PBSP was from 2010, and did not include the newer information; and Individual #606, for whom the data for many relevant sections of the updated PBSP were missing.<br><br>Review of key elements from the 12 PBSPs that had information in the current format showed the following:<br>• <u>Psychiatric Diagnosis:</u> PBSPs for 12 of 12 (100%) of the individuals contained the individual's diagnosis or diagnoses. In all cases it was in the DSM format and the cited diagnoses that were consistent with the information contained in the psychiatric evaluations.<br>• <u>Identification of the problem and need for behavior supports:</u> This PBSP section | Noncompliance |

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| | | typically outlined the general problems the individual experienced and the interventions used to provide needed supports. For nine of 12 (75%) of the individuals, psychotropic medications were identified in the PBSC section as one of those supports.<br>• Psychiatric case formulations: These were present in 12 of 12 (100%) of the PBSPs.<br>• Differentiation of learned problem behaviors and psychiatric symptoms/behavioral characteristics: In previous compliance reviews, the Monitoring Team noted that there were many instances where the targets of medication treatment were the same as the target psychiatric symptom. In such cases a relevant clinical question was whether the medication was used to treat a psychiatric disorder or whether it is used non-specifically for behavior control. The Facility has responded to this issue by elective inclusion of a section in the PBSP that outlined how the IDT understood the differentiation of the two kinds of behaviors. There were sections for this item in four of 12 (33%) of the records. These were very helpful in providing an overall understanding of the individual's symptoms. For example, for Individual #673 the PBSP stated: "(the Individual's) speech is a learned behavior however the repetitive/pressured nature of her speech arises from axis 1 diagnosis of anxiety and (genetic syndrome). Zoloft has helped decrease this behavior, presumably by decreasing the motivating operation of anxiety. Also it has been noted that this behavior increases during times (such as illness and death of a close peer) when anxiety would be expected to increase."<br>• Information describing the medication and how it is used. PBSPs were reviewed for the manner in which details about medication treatments were provided. In previous reports the Monitoring Team had expressed concerns that PBSP medication information did not contain needed information about the reasons that the medication was used, the goals of the treatment, possible side effects, and so forth. To provide more clarity, the Facility has now incorporated the psychiatrists' MPs into the PBSPs. Such MPs were included in 11 of 12 (91%) of the PBSPs. Individual #271 had a summary of medication information but not the MPs. Further information about MPs is included as part of the discussion of Provision J13. Overall, the Monitoring Team found that the methodology of inclusion of the MPs in to the PBSPs was effective, since it provided the needed information as written by the psychiatrists who prescribed the medications.<br>• Monitoring for treatment efficacy: With the revised PBSP sections in place, information about why medication is prescribed is much clearer. However, to more fully understand medication use, the Monitoring Team needed to understand how treatment efficacy was evaluated and data on treatment efficacy needed was needed. As outlined in previous reports, those assessments needed to include objective data. For the PBSPs that were reviewed, 12 of 12 (100%) presented some kind of information about treatment efficacy, and 11 of | |

12 (91%) provided graphic presentations of the psychiatric data. This represented good progress toward inclusion of the needed objective psychiatric data. However in a number of areas difficulties were noted:

- Whereas the behavioral targets for intervention were defined in the PBSPs, for 11 of 21 (91%) of the individuals, assessed psychiatric symptoms/behavioral characteristics were not. For example, irritability (Individual #28), depressive symptoms (Individuals #622 and #349), anxiety (Individual #250), and psychosis (Individual #349) were not defined.
- Many graphs for psychiatric symptoms reported information on a 0-3 scale for severity. However, how severity was assessed was not clear. Examples were Individuals #28, #250, #349, #216, #127, and #255.
- Other graphs for psychiatric symptoms reported information on the frequency of the symptoms. In some cases it seemed clear that absolute frequency rates for the month were reported. Examples were ratings for Individuals #271 and #482. But in other cases it was not clear to the Monitoring Team whether the rating was for the frequency or severity of the symptoms. Examples were Individuals #230 and #673. In some cases the graphs included a key that clarified the matter, but not in the cited cases.
- For some individuals there were graphs for both behavioral and psychiatric data, but it was not clear how the selection was made for the inclusion of the particular behavior/symptom in the particular graph. For example, for Individual #482 "hyperactivity" is reported only on the behavioral graph although for that individual hyperactivity is a psychiatric measure of concern.

Overall, the Monitoring Team observed that in some long standing behavioral plans, symptoms of interest to psychiatry did have the needed definitions. For example, "suicide gestures" were included and defined in the PBSP for Individual #255. Similar clarity about what is being rated needed to be part of the newer data-based reports for psychiatry.

<u>Appropriate use of medication:</u>
As mentioned for Provision J2, the Monitoring Team assessed various aspects of the clinical process, by observation of the psychiatrists' day-to-day work in the various settings and meetings where individuals were seen and their care discussed. The primary place where routine decisions on elective medications were made was during PMRs.. During the three PMRs attended during the visit, the following observations were made about medication use and the assessment of medication effects:

- For Individual #133: The graphic presentation of medication dose and

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| | | psychiatric symptoms was good. The psychiatric symptoms monitored (impulsivity, irritability, and insomnia) were relevant for the diagnosis of ADHD, and the graphing was done so that the time frames for medication doses and symptoms (displayed on different graphs) lined up correctly and examination of the data from the different graphs was possible. The graphs allowed the reader to quickly see that the gradual decrease and eventual discontinuation of lithium had no impact on the target symptoms. The data confirmed that (at least for the cited purposes) the medication seemed unnecessary. As noted in the above discussion for PBSPs, impulsivity and irritability needed to have been defined and were not.<br>• For Individual # 472: The graph did not have a key that made it possible to be clear what the dose of Risperdal was, and the information on psychiatry symptoms used a different time scale than the information on medication dose.<br>• For Individual #271: Discussion of medication information was directed, appropriate, and differentiated from more general discussion of behavior control. Separate graphs were presented for psychiatric symptoms and behavioral targets, and the data made clear that they tapped different sorts of data. The discussion of psychiatric medication and symptoms made clear that the use of medication was monitored and directed by the psychiatric symptom data and the use of medication was appropriate.<br><br>The Monitoring Team also attended the annual ISP for Individual # 250. The ISP presentation by the psychiatrist included a review of the medication given to that individual. The medications provided for anxiety and for sleep were appropriate for the individual, and were well integrated into the overall treatment plan.<br><br><u>Medications used for staff convenience:</u><br>The Monitoring Team addressed whether medication was used for staff convenience by examination of the records, and by observations made during PMRs and other activities during the visit, and by interviews with staff. There was no evidence that medications were used for staff convenience.<br><br><u>Medications used for punishment:</u><br>To determine whether this was ever done, the Monitoring Team considered observations made during the tour, and reviewed the records of the 15 individuals in Sample J2. There was no evidence that medications were used for punishment.<br><br><u>Chemical Restraint:</u><br>There was only one use of chemical restraint during the review period, for Individual #537, on 8/20/12. The individual had experienced considerable psychiatric difficulty around that time, and there was no suggestion that the chemical restraint was used for convenience or punishment. Procedures for the episode of restraint were followed. | |

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| | | Overall, the feedback from the Monitoring Team is that the way information about medication use is presented is increasingly clear and transparent. Continued efforts are needed, however. In particular, efforts are needed to improve the monitoring of psychiatric information for treatment response, as detailed above. | |
| J4 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects. | <u>Medical monitoring of medical restraint (pre-treatment sedation):</u><br>Since the last compliance tour the Facility had shifted to the use of DADS Procedure 001.1 Use of Restraints (04/10/2012). The new procedures included a new DADS Medical/Dental Restraint Checklist. The checklist included a template that spelled out the particular time points in the procedure when vital sign and related safety checks were to be done. The Monitoring Team reviewed how nurses monitored for safety during pre-treatment restraint procedures. This was done by review of the nursing care protocols, the nursing guidelines for nursing responsibilities related to restraints, and the training of nurses for such monitoring. The latter took place during a meeting between the Monitoring Team and representatives of the Nursing Department, on 10/09/12.<br><br>The Monitoring Team confirmed that for oral pretreatment sedation, procedures for vital sign monitoring were:<br>• Prior to the procedure: Pre-medication baseline and then every 30 minutes<br>• After the procedure: Every 30 minutes x 2, then every two hour x 2, then every four hours for 24 hours.<br><br>For post anesthesia care (TIVA) monitoring was:<br>• In the recovery area (infirmary): Every 15 minutes for one hour, then every 30 minutes for one hour until a REACT score of eight is achieved. The REACT score was a measure of alertness; higher scores indicate a higher level of alertness.<br>• On the home: Every two hours x two, then every shift for 72 hours.<br><br>The Monitoring Team reviewed the 18 cases of use of pre-treatment sedation out of the roughly 450 that took place during the review period (about 4%). Only nine of 18 (50%) of the cases reviewed used the new medical/dental restraint checklist, which was put in place during the review period. These nine cases were Sample J3, and each of these sedations was reviewed. Vital signs, including baseline measurement for oral pretreatment sedation, were obtained for all individuals. Physician/Dentist orders outlining the type and frequency of safety monitoring were provided in all cases. In TIVA cases, REACT scores were obtained in the recovery/infirmary area, prior to the individual's being released to the home.<br><br>A number of problems were noted, however, and most related to monitoring for safety. Most of these were during/after TIVA procedures. For TIVA procedures, 72 hours of monitoring was required, but in three of nine (33%) cases, documentation during the | Noncompliance |

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| | | latter part of that period could not be confirmed. It was difficult for the Monitoring Team to confirm that vital sign monitoring took place in the infirmary at the required intervals after completion of the TIVA procedure. This may have been due in part to the way documentation took place in the recovery area which appeared to vary from case to case. In some cases infirmary documentation was listed on the old post sedation monitoring form and subsequent monitoring was on the new form. At other times, a separate sheet of infirmary information was used and it was attached to new restraint form. On yet others, Facility nurses used the new restraint form. In two of nine cases (22%), no infirmary documentation was received. In one case (Individual #684, an oral pre-treatment sedation) there was a lengthy lapse in vital sign monitoring and the protocol was apparently not followed.<br><br>The Monitoring Team tried to understand how and where the apparent breakdown in procedure occurred, and what might be done to improve the monitoring. A useful meeting took place during the visit on 10/09/12 with the nursing department and these matters were discussed. As a general observation, the Monitoring Team noted that the new medical dental restraint form was organized in a way that was intuitive and straightforward for vital sign monitoring for oral pretreatment: The restraint form provided a place for documentation of vital sign monitoring for 25 hours. There is a section for "RN/LVN Pre-Treatment Monitoring Pre-Appointment V/S = Baseline; q 30 minutes until departs location" and there is a different section for "RN/LVN Post-Sedation Monitoring post sedation VS = arrival; q 30 x2; q 2hrs x2 then q 4 hrs x 24 hrs". However, how the form should be used for TIVA was less obvious. For most (but not all) individuals who received TIVA there was no oral pretreatment sedation. The IV drugs, of course, preceded the dental treatment and were therefore still pre-treatment, but documentation of that was part of the TIVA anesthesia record and was not on the medical restraint form. It was also not clear when "post sedation" monitoring started. After the TIVA procedure, the individual was first seen in the recovery/infirmary area until stable. When the individual was determined to be stable he/she was released to the home and monitoring continued. From a standpoint of the restraint form, it was not clear whether the time for recovery in the infirmary should be considered part of TIVA procedure, or part of the post sedation period. In short, it was not clear how the nurse monitoring for safety that followed the procedure should be documented on the new medical restraint form. As a general matter, it was clear to the Monitoring Team that the new forms were not being used in a consistent matter during sedations, and that made both the provision of care and the monitoring of the care more difficult. During the visit the Monitoring Team recommended to the Facility that for TIVA procedures, guidelines should be provided to nurses about how information from the infirmary recovery area should be integrated with the new medical/dental forms. Similarly, guidelines should be provided regarding documentation of vital signs, for the period of time between the end of the medical/dental restraint form at 25 hours, and the remainder of the 72 hour monitoring period. Appropriate training on the use of the new forms should then be | |

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| | | provided.<br><br><u>Efforts to reduce the need for medical restraints during routine medical and dental procedures:</u><br>During the Entry Interview, Ms. Wooten presented a graph that showed that Facility use of pre-treatment sedation had declined during June, July and August 2012, compared to the previous several months. Exact figures were not reported, but the graph show rates of about 100 uses of pretreatment sedation each month in May and June 2012, and 60 or less sedations in each of the months that followed.<br><br>On 10/09/12 the Monitoring Team met with Ms. Bishop, Dr. Wear, and Ms. Wooten to review Facility efforts to reduce the need for pretreatment sedation. The Facility procedure on desensitization clarified that in general, three attempts should be made to treat the individual without sedation before pretreatment sedation is considered. If Medical/Dental sedation was required for the routine medical or dental treatment, the individual was to be referred to the IDT to consider efforts to reduce the need for use of the sedation. To further the process the Facility has now defined what constitutes routine and non-routine dental procedures. Routine appointments included dental exams and x-rays, dental cleanings in the absence of periodontal disease, fillings or restorations that do not require manipulation of soft tissue, and impressions for removable appliances or the fabrication of study molds. Non-routine procedures included extractions, any procedures that invade the pulp, and any procedures that require manipulation of soft tissues.<br><br>The Monitoring Team reviewed the status of the Facility-wide development of plans to reduce the need for pretreatment sedation. During the last visit the Monitoring Team was provided with a list of 153 individuals who had some kind of a plan in place to reduce the need for pre-treatment sedation. During the current visit the Facility provided a list of individuals who had "Desensitization Plans" for dental procedures. These were in place for seven individuals; there were no plans in place for medical procedures. Since desensitization and other treatment plans are often best done in the setting that evokes the challenging behavior, the Facility has reserved space in the dental suite on Wednesdays, for behavioral treatments to take place. The Facility provided the Monitoring Team with copies of such programs for Individuals, #2 and #204. Each plan contained instructions for staff to have the individual sit for gradually increasing amounts of time in the dental chair in the dental suite. The first step of each program had the goal of the individual staying in the dental chair for a brief moment. The fifth step was for the individual to stay in the dental chair for one minute. Data sheets for each individual showed the manner in which the training was implemented.<br><br>As described above, the Monitoring Team selected a small sample of nine instances of pretreatment sedations that took place during the review period (Sample J3). In one case | |

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| | | the ISP was not provided. For the remaining ISPs six of eight (75%) indicated that pre-treatment sedation was needed, an action plan to provide a behavioral intervention was part of the ISP for two of eight (25%) individuals, but none had evidence of implementation of a plan and none had data sheets that indicated that a plan was in place.<br><br>During the meeting with Ms. Bishop, Ms. Wooten and Dr. Wear, the Facility outlined the overall strategy for continued development of treatment plans for those individuals who needed them. Ms. Bishop described her work as the psychology assistant assigned to work on reducing the need for pre-treatment sedation. She articulated the understanding that for a minority of individuals, a formal skills acquisition program – in some cases a formal desensitization program- is needed. For other individuals, supports built into the overall ISP are the best approach. For some individuals, that might initially take the form of encouragement of the individual's participation in his/her overall oral hygiene efforts. For others, it could be that during visits to the dental clinic or other sites where pre-treatment sedation takes place, the individual might be accompanied by a preferred staff member who could provide additional support and assurance. For other individuals, reluctance to participate in medical procedures might be part of an overall anxiety problem. In such cases, the intervention might be enhanced efforts by psychology and psychiatry staff to develop and implement treatment plans to more effectively treat that anxiety. The group discussed the data mentioned above about the decreased use of pre-treatment sedation in recent months. The Monitoring Team also noted the improvement in dental clinic services that were reported under section Q of this report. The Monitoring Team was also impressed by the energy and dedication of Ms. Bishop in her efforts to assist IDTs as they organize efforts to focus on encouraging individuals to feel comfortable with routine medical and dental procedures, so that they do not need sedation.<br><br>The above positive developments notwithstanding, the overall process of development of an integrated Facility plan to address unnecessary use of pretreatment sedation remained at an early stage, and many individuals who needed APs to reduce the need for pre-treatment sedation did not yet have them. Some evidence for that was the sample reviewed by the Monitoring Team that showed that although the IDTs knew that a treatment program was needed, an AP was not provided. To try and quantify what the underlying need might be, the Monitoring Team requested additional information about the provision of dental services: Of the 493 individuals who lived at the Facility, 62 were edentulous and 29 were diagnosed with involuntary movements that might necessitate continued use of pretreatment medication. Of the remaining individuals, 134 of 402 (33%) required IV sedation for dental treatment and 36 of 402 (9%) required oral pretreatment sedation. Some individuals required both, as oral pretreatment sedation was sometimes needed to overcome reluctance of the individual to go to the dental clinic. | |

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| | | For each individual who required pre-treatment sedation, the generalities discussed above need to be articulated in the manner of a program that is specific for the individual, described in an AP, and reviewed and approved by the Human Rights Committee (HRC). In terms of eventual compliance with the requirements of the SA, the Monitoring Team will also expect the Facility to provide internal quality assurance (QA) efforts to determine efficacy of individual plans to reduce the need for pre-treatment sedation and to respond with improvements, as indicated. | |
| J5 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement. | At the time of the visit, 239 of 492 (49%) of the individuals who lived at the Facility received psychiatric support.<br><br>The Facility continued to employ three full time staff psychiatrists.<br><br>Dr. Salam was the Lead Psychiatrist. In this role Dr. Salem was responsible for many facility-wide activities, which included management of facility-level reviews such as polypharmacy and management of the Facility-level reviews of individuals known to have tardive dyskinesia. She was also responsible for preparing the Facility Self-Assessment for psychiatry and for coordinating the response to the Monitoring Team's comments. During the review period she led the Facility efforts to revise the response to Reiss Screens, since these are included in the psychiatry section of the SA.<br><br>Drs. Satpathy and Habbu continued as a full time Staff Psychiatrists and were active with several Facility Committees.<br><br>Dr. Harden continued as the contract psychiatrist for four half-days per week. His work focused on QA for psychiatry. However, at the time of the visit, Dr. Harden was on medical leave. As of September 2012, the Facility hired Dr. Howard Lagrone (also a contract psychiatrist) to complete the QA duties usually provided by Dr. Harden. The Monitoring Team did not review any of Dr. Lagrone's work.<br><br>Drs. Habbu, Salam, Satpathy and Harden all carried clinical caseloads. Drs. Habbu, Salam, and Satpathy had clinical caseloads of 73, 69, and 73, respectively. Dr. Harden had a caseload of 26 individuals. In his absence, the staff psychiatrists assisted with clinical coverage for those individuals.<br><br>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 PRC. 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 | Substantial Compliance |

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| | | 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.<br><br>In the previous report the Monitoring Team reported that it concurred with the Facility 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. That remained the case. The Monitoring Team was informed that Dr. Harden should be able to return to work soon and should be able to resume care for his individuals on his caseload. That should lighten the load on the staff psychiatrists who are providing support for those individuals while he is away.<br><br>The Monitoring Team noted that the Lead Psychiatrist was carrying essentially the same caseload as other staff psychiatrists, despite the many responsibilities inherent in her work as the Lead psychiatrist. The Facility should consider re-assignment of some of the individuals under her care to the other psychiatrists, to allow her the needed time to attend to the clinical/administrative responsibilities inherent to the role of Lead Psychiatrist. | |
| 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 15 individuals in Sample J2. Psychiatric evaluations in the required Appendix B format were in place for all 15 individuals. The overall length of the evaluation varied from 7 to 10 double spaced pages and all elements of the required evaluations were present. All psychiatric diagnoses were in the DSM IV format, and they did not include NOS diagnoses.<br><br>In the previous compliance report the Monitoring Team focused on the need to improve the manner in which the psychiatric diagnoses were justified. To evaluate progress in this area, each evaluation was reviewed to assure that documentation was adequate to fully substantiate the psychiatric diagnoses in terms of all of the symptoms that are required to fulfill the complete diagnostic criteria listed in the DSM IV TR or the Diagnostic Manual of Intellectual Disability (DM-ID). Overall, there was progress in this area, as in the judgment of the Monitoring Team, 7 to 15 (46%) of the evaluations met that requirement.<br><br>Example of evaluations that provided adequate diagnostic justifications were:<br>• Individual #28, for whom the psychiatrist wrote "(the individual) has suffered from episodic mood symptoms (extreme irritability, mood lability/crying spells, sleep disturbance, agitation, aggression, impaired self care/hygiene and uncooperative behaviors) indicative of depressive type of mood disorder. There is no clear history of discreet (sic) depressive episodes. Rather, (the | Noncompliance |

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| | | individual's) depressive symptoms are chronic in nature and fluctuate in intensity. There is no known history of mania or psychosis. Based on this information her diagnosis of Dysthymic Disorder is maintained." In this case the psychiatrist provided information pertinent to the chosen diagnosis, and information that informed the reader why other mood disorder diagnoses were rejected.<br>• Individual #622, who was diagnosed with major depressive disorder, recurrent, moderate without psychosis. The psychiatrist addressed the core requirements regarding the severity of the disorder by commenting that the individual has "Recurrent depressive episodes consisting of sad/irritable mood, frequent crying reduced appetite and weight loss, lack of preferred activities and social isolation in the absence of mania or psychosis. (The individual) experienced depressive symptoms when she was taken off antidepressant treatment."<br><br>Examples of evaluations that did not provide adequate diagnostic justification were:<br>• Individual #182, who was diagnosed with Bipolar Disorder 1, in partial remission, 296.45. The psychiatrist wrote that "the history of developmental delay, cognitive adaptive deficits, mood lability, irritability, impulsivity, aggression, maladaptive behaviors etc. meet criteria of axis 1 and axis 2 disorders. " The diagnosis may well have been correct, but the justification did not address the specific requirements of the diagnosis.<br>• Individual #230, who was diagnosed with Autism. The past psychiatric history reported a diagnosis of obsessive-compulsive disorder made in 1999 and a remote history of some manifestations of temporal lobe seizure activities. The "diagnosis" section of the evaluation was not accompanied by any text explaining the choice of diagnosis, and the case formulation stated only that "considering her language development impairment, increased anxiety due to her routine schedule and environmental change, her fixed engagement with puzzles and occasional aggression the patient is most likely having (sic) Autistic Disorder." In the opinion of the Monitoring Team a sole diagnosis of autism may well have been correct. However, there should be a more detailed delineation of the reasons that autism was selected, for example over a less specific diagnosis of pervasive development disorder. There should also be a discussion of the reasons that other diagnoses, for example anxiety or OCD, were rejected.<br><br>The Monitoring Team also notes that continued attention is needed in the area of case formulation. The core of what is needed for case formulation is a synthesis of the extensive information provided in the various sections of the CPE, so as to provide an integrated bio-psycho-social understanding of the individual from which a treatment plan was derived. At minimum, what was needed was an understanding of how key influences from various domains contributed to the behavioral characteristics exhibited by the individual, and from that how treatments were selected. An example in which this | |

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| | | was done was Individual #622 (cited above) who had a major depression characterized by many of the classic neurovegitative signs of that disorder. Psychotropic medications were required to maintain her level of function and without them, she relapsed. In the case formulation the psychiatrist explained the role of behavioral interventions in the overall care of the individual by stating that "her current PBSP and other supportive interventions seem effective in reducing maladaptive behaviors and greatly reduced the frequency of current target behaviors."<br><br>In previous visits the Monitoring Team had commented on the need for psychiatrists to include key information in annual reviews/updates, so the information could be easily accessed when needed. To follow-up on this matter, the Monitoring Team reviewed the most recent CPEs for the three individuals in Sample J4. These were individuals who had changes in diagnosis during the previous year.<br>• For Individual #61 the CPE of 9/18/12 stated that on 12/21/11 an evaluation was done and "due to a direct correlation of mood changes with increased pain level diagnosis is changed from depressive disorder NOS to Mood Disorder – depressive type secondary to chronic pain. RN CM will follow-up with Primary Care Provider (PCP) regarding pain management." That note was direct, focused, informative, and substantive. It provided what was needed at the level of the CPE in terms of clinical justification. If more detail was needed, the primary materials could be located. This was also an example of integrated care, since the re-diagnosis led to involvement of the medical team to address an underlying cause of distress.<br>• For Individual #371 the annual CPE done on 08/07/12 included the addition of the diagnosis of personality change due to encephalitis (310.1) that had been made during the course of the prior year, on 11/02/11. The developmental history recorded in the CPE made mention of the episode of early childhood encephalitis that was the basis for the diagnosis. However, the "psychiatric summary of the past year" section of the CPE did not mention the re-diagnosis itself or the reasons that led the psychiatrist to conclude that information on the encephalitis was best coded on Axis 1 as etiologic, rather than Axis III as a relevant historical diagnosis. One presumes that this was a matter of judgment that was probably informed by the combination of the severity of the infection and its location in the brain, but a sentence or two that made the judgment explicit would have added to the understanding of the diagnostic choice.<br><br>Overall, it was good that the annual CPEs reviewed for previous changes in diagnosis did include the updated information. The CPEs should be improved by inclusion of information regarding the clinical justification for the changes.<br><br>Overall, the Monitoring Team agrees with the Facility self-assessment that improvements were needed related to the justification for psychiatric diagnoses and clarity of identified | |

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| | | symptoms. Continued attention is also needed to the quality of case formulations, and the area of inclusion of information on changes in diagnoses in subsequent annual evaluations.<br><br>Further comments regarding case formulation are included under Provision J8. | |
| 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 this compliance visit, there were 239 individuals under the care of the Psychiatry Department. Each of these individuals had received a CPE, and they were not required to have a Reiss Screen in place. This included Individual #273, admitted to the Facility on 05/30/12 and for whom a CPE was completed on 06/07/12.<br><br>The total number of individuals who lived at the Facility was 492. Accordingly there were 253 individuals for whom a Reiss Screen was needed. As reported during previous visits, Reiss screens were completed for these individuals. In the report for the April 2012 compliance visit, there were 15 individuals who had positive Reiss screens, and who had not received CPEs. The Facility reported that as part of an internal review of Reiss Screen administration, Reiss screens were re-administered to these individuals. The results of the Reiss Screen re-administrations were that only two of the individuals had positive screens. Internal review by the Facility showed that in some cases, adequate training may not have been provided to the individuals who gave and scored the screens.<br><br>In order to assure that Reiss Screens had the highest quality, the Facility has decided to provide proper training on test administration, and to start the process anew for all 254 individuals who needed the screening.<br><br>The Monitoring Team also enquired about plans to provide periodic Reiss screens for individuals who live at the Facility and who are not followed by psychiatry. The Monitoring Team was provided with a draft proposal to do so. | Noncompliance |
| J8 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. | There continue to be many places in the clinical process where psychiatrists, psychologists, and other IDT members work side-by-side to generate the combined assessments and case formulations that are required by this provision. Some of these are the PMR clinics, medical reports, and the polypharmacy and ISP meetings observed by the Monitoring Team during the current compliance visit (see provision items J2, J3 and J11 and J15). Based on current and past observations, the Monitoring Team determined that appropriate clinical meetings were in place for multidisciplinary and interdisciplinary assessments to take place.<br><br>The Facility's plans to bring information together to provide the required assessments were outlined in the Action Plan provided by the Facility. The four elements of the Action Plan brought together contributions from the clinical meetings and discipline- | Noncompliance |

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| | | specific assessments, into the PBSP and the ISP. That was appropriate, since the PBSP presents the combined work of the behavioral healthcare team, and the ISP presents the overall work of the entire IDT.<br><br>The Facility reported that work on this part of the Facility's Action Plan was in process, and a projected completion date of 04/05/2013 was provided. To monitor the progress of the Facility, the Monitoring Team examined PBSPs and ISPs of the 15 individuals in Sample J2. The presentation of the findings of the Monitoring Team follows the outline of the Facility AP.<br>1. <u>PBSP to be completed in a timely manner following the new format with integration of information from psychology and psychiatry:</u> The new format in question had now been in place for seven months, since 2/23/12. A key element was the inclusion in the PBSP of the section for a combined case formulation. The case formulation is an electronic copy of the bio-psycho-social formulation from the psychiatrist's CPE. While those case formulations are inclusive, they are nonetheless formulations written by a member of one discipline. PBSPs properly describe these summaries as "psychiatric case formulations" when they are included in the PBSP (see discussion under provision J3). It is not surprising that the case formulations written by the psychiatrists are generally strongest regarding the psychiatric elements of the case. While they are a good basis for the combined case formulation, a stronger contribution from psychology is needed for the purposes spelled out by the language of this provision. Perhaps the Facility should consider asking the psychologists to be available when necessary, to more actively join with the psychiatrist in the writing of the case formulation of the CPE. This would potentially allow the product to be sufficient not only for the purposes of the psychiatrist's CPE, but also for the additional purpose that the Facility desires.<br><br>In addition to the combined case formulation section, the Facility revised (effective 01/23/12) the PBSP format to include a section called "Differentiation between Learned Problem Behaviors and Psychiatric Symptoms. These were present for 4/13 (31%) of the records. For example, the PBSP for Individual #673 stated: *"(the Individual's) speech is a learned behavior however the repetitive/pressured nature of her speech arises from axis 1 diagnosis of anxiety and (genetic syndrome). Zoloft has helped decrease this behavior presumably by decreased the motivating operation of anxiety. Also it has been noted that this behavior increases during times (such as illness and death of a close peer) when anxiety would be expected to increase."* This description helped understand the roles behavioral and psychiatric treatments play.<br>2. <u>PBSP to include discussion about psychopathology, MPs, tracking of data for psychiatric symptoms and combined psychiatric and psychological assessment of the individual</u>: All PBSPs listed the DSM diagnosis. Information about the | |

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| | | psychopathology was present in all PBSPs, either under "Identification of Problem and Discussion," and or in the "Need for Behavior Supports" section. Tracking of psychiatric data remained in early stages of development. More detailed descriptions of all these matters are discussed under provision J3.<br>3. Discussion of a treatment plan in the PBSP that includes least restrictive plans, rationale for selecting a particular treatment intervention and use of non-pharmacological interventions to support the individual. This is the information required by Provision J9, and the Monitoring Team's observations are reported under that provision.<br>4. Integration of information from psychiatric assessment and treatment plan in a meaningful manner in the ISP document, and in the development of risk action plans. ISPs for all 15 individuals in Sample J2 were reviewed. ISPs varied considerably as to whether or not needed psychiatric information was provided. In general, the Monitoring Team looked to see whether the ISP made clear what the individual's psychiatric needs were, and whether the action plans for the individual provided specifics. Some examples of each were found. For example, Individual #230 had a behavioral treatment summary that outlined of the types of treatment (medication, various elements of the PBSP, functional communication training) that have been helpful for the individual in the past. The ISP for Individual #271 contained a living options discipline recommendation that reported that "psychiatry mentioned that (the individual) could live in a community setting, at least in terms of his low rates of challenging behaviors," and the ISP had a "review of all assessment recommendations" that indicated that he would need medication management and quarterly psychiatric appointments. The ISP for Individual #250 provided guidance about the level of support that is needed. As a general matter, there was no consistent presentation of current and projected psychiatric supports.<br><br>In summary, progress has been made regarding integrated care at the level of the behavioral health care program, as reflected in the PBSP. Progress on behavioral healthcare integration at the overall level of the ISP was more limited. | |
| 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 | The provision item required that before a proposed PBSP was implemented, the IDT needs to determine:<br>(a) That the least intrusive and most positive interventions to treat the psychiatric condition were used<br>(b) That medication treatment would also be accompanied by non pharmacological support,=<br>(c) Whether the individual was best served though behavioral, pharmacological or other interventions, in combination or alone<br><br>During the review, the Monitoring Team reviewed both the how these determinations | Noncompliance |

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| | condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible. | were made, and how they were documented in the record.<br><br>As reviewed under Provision J2, the primary place where the clinical discussion took place was the PMR clinic, which was attended by the psychiatrist, psychologist, QMRP, nurse case manager, and DSPs. At times, LARs or others also participated, either in person or via telephone contact. Primary Care Providers (PCPs) typically did not attend, but when their input was needed they were contacted by telephone or their inclusion in the decision making was done by conversation with the psychiatrist after the meeting. There were many points of contact between the psychiatrist and PCP during the daily work so that such communication was certainly possible. As described under Provision J2, the team process in place was positive.<br><br>The Monitoring Team reviewed the records for the 15 individuals in Sample J2, for the presence of the needed determinations.<br><br>For items (a) and (b), documentation was typically located. For the 12 PBSPs available (see description of this sample under Provision J3), documentation was found in 12 of 12 (100%) of the cases. For example:<br>• From the PBSP implemented 09/29/11 for Individual #622:<br>o "(The individual) has been diagnosed with Major Depressive Disorder – recurrent, moderate without psychosis. Less intrusive methods have been unsuccessful in decreasing episodes of physical aggression toward others and stripping. In 2000 (the individual) was removed from all medications to enable the psychiatrist to establish a baseline during which she became very depressed and difficult to engage. Exclusionary timeout was used with good results in the past but has been deemed to be no longer appropriate."<br>o The PBSP contained behavioral interventions to track and decrease the incidence of physical aggression to others (PAO) and stripping clothing. Behavioral interventions were in place to increase adaptive alternative behaviors, in this case to indicate that she wants a bath through speech by saying or leading behaviors such as motioning to follow her and leading staff to the bathroom while remaining dressed.<br>• From the PBSP implemented 08/03/12 for Individual #216:<br>o Revision of the PBSP supported non-restrictive practices in place that had been effective at preventing and managing the symptom of aggression. Such efforts included differential reinforcement of alternative behaviors, physical blocking, and antecedent management strategies.<br>o The PBSP contained behavioral interventions to decrease physical | |

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| | | aggression to others, and negative statements. The PBSP contained behavioral interventions to increase appropriate verbal requests.<br><br>Adequate documentation of whether the individual was best served though behavioral, pharmacological or other interventions, in combination was found for four of 12 (33%) of the individuals. Examples of documentation that addressed this matter were:<br>• Individual #28, who had a PBSP that stated: *"Behavioral services remain warranted due to the severity and intensity of (the individual's) problem behaviors. Her diagnosis of Dysthymic Disorder often presents with (symptoms described) and the antidepressants help with easing that. Her target behaviors also impacted her ability to work, participate in social activities, and develop appropriate relationships. The PBSP helps to offer stable interactions and consistent supports."*<br>• Individual #250, who had an annual ISP plan during the visit. Background information for the ISP included his annual psychiatric review with language for his revised PBSP. The package included a MP for trazodone. The MP contained the following language regarding medication for insomnia:<br><br>"*Trazodone was chosen after melatonin failed and his mother was provided with information regarding benefits and side effects of this medicine in comparison to alternative (medication) treatments… (The individual) will continue to be encouraged to practice sleep hygiene"*<br><br>The statement showed that there was individualized attention to the determination that in this case, the individual was best served through the provision of the proposed medication, in combination with the behavioral intervention of good sleep hygiene.<br><br>But many records needed to better address which modality or modalities or treatment were the best clinical choices to address the problem(s) at hand. | |
| 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 | The provision required that before non-emergency administration of medication there needed to be an IDT risk/benefit analysis of the proposed medication that included the psychiatrist, PCP and nurse. This grouping of professionals also needed to evaluate alternative treatment strategies.<br><br>The place where discussions about medication (including risk/benefit analyses) took place was the PMR. 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, but that was not common. When the PCP was not present and a MP was developed, the psychiatrist called the PCP, and discussed the relevant issues. Discussion of medication issues and discussions about risks/benefits could also be part of any IDT discussion. PRC, P&TC, and the medical morning report | Noncompliance |

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| | medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications. | were some of the settings where such issues were also discussed. These processes were appropriate to provide the review of the information required by the provision.<br><br>During the compliance visit the Monitoring Team reviewed the clinical process with the Lead Psychiatrist, who provided assurance that the relevant issues were discussed by the required individuals. The conversation then turned to a discussion about the level of detail required for each requirement, and to the documentation of clinical discussions. The Lead Psychiatrist indicated that the MP contained an item for Risk Benefit analysis, and a section for discussion about alternative treatments was added to the MP template effective 06/20/2012. These were the best places for the team to document the decisions about new medications.<br><br>The Monitoring Team reviewed the 21 new medications proposed by the Facility during the review period, and that constituted Sample J5. Results were:<br><br><u>Risk Benefit Assessment:</u> For each of the 21 medications, there was an MP that contained a risk/benefit analysis. The level of analysis varied greatly. Some of the MPs contained a detailed and individualized descriptions that clearly met the requirements for risk/ benefit assessment. For example:<br>• Individual #373 (for Lunesta): "(The individual) was taken off Lunesta four months ago while she was experiencing drowsiness during the day from side effects of another medication. Now her condition is much better and she is awake and active during the day. Her chronic sleep problem has reoccurred which is causing her to have difficulty falling, maintaining and staying asleep. (The Individual) had an excellent response to Lunesta in the past after failing to respond to several medications and there were no reported side effects from Lunesta. When (the Individual) has stable sleep she appears less irritable and more alert and coherent in her thought. Her guardian and IDT agree to restart the medication and begin with a smaller dose.<br><br>Benefits of Lunesta outweigh the associated risks/side effects due to the expected improvement in sleep disturbance. MOSES is conducted on a quarterly basis by the nurse case manager to monitor side effects; pertinent in the case of Lunesta are altered taste, headache, dizziness, drowsiness, nausea and dry mouth."<br>• Individual #686: (for Ativan): (The Individual) is experiencing new onset insomnia and behavioral changes. Sleep disturbance and agitation/aggression disrupt her routine and affect the quality of life and participation in activities. It is also associated with noncompliance to medical treatment. Environment and PBSP supports are not helping and she has been sent to the ER twice where she received a combination of medications to calm her down. Due to the recurrence of symptoms IDT and parents agree to start Ativan until the evaluation /workup | |

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| | | can be completed to ascertain the cause of these problems and long-term benzodiazepine use will be avoided. (The Individual) tolerated and responded well to Ativan when administered in the emergency room and is considered a safer anti-agitation medication compared to antipsychotics due to increases in seizure activity. The nurse case manager conducts MOSES to monitor side effects; pertinent Ativan side effects include sedation, weakness, unsteadiness, drowsiness, and confusion and memory problems.<br>• Seven of 21(33%) examples were rated as clearly meeting the required standards.<br><br>Some MPs limited the presentation to a listing of the main symptoms that could be controlled by medication, and the main side effects that could be incurred. For example:<br>• Individual #222 (for Remeron): "Benefits of symptom control (decrease in anxiety, sleep improvement, weight gain etc.) outweigh potential risk. Adverse effects monitored are sedation nausea dizziness constipation etc."<br>• Individual #67 (for Seroquel): "Benefits of symptom control (decrease in paranoia, disorganized behavior, aggression, etc.) outweigh potential risk. Adverse effects monitored are sedation, weight gain, metabolic syndrome, extra pyramidal side effects, dyskinesia, etc.<br><br>Such presentations were not optimal but were assessed by the Monitoring Team to meet the minimal requirements. Nine of 21 (42%) of the MPs were rated by the Monitoring Team as meeting minimal requirements.<br><br>Some MPs did not provide enough information. For example:<br>• Individual #449 (Klonopin): "Benefits of Klonopin outweigh the risk/side effects (sedation, dry mouth dizziness)."<br>• Individual #702 (Seroquel): "Benefits outweigh the risk/side effects which include metabolic syndrome, drowsiness, dry mouth, dizziness and lightheadedness."<br><br>Five of 21 (24%) of the MPs were rated as not sufficiently detailed, since at minimum, both the main benefits and potential side effects should be listed.<br><br>For existing medications, the system in use at the Facility was that MPs were (re) written annually, This was a good practice, but when it is done it would be appropriate for the psychiatrists to comment on risk/ benefit on the basis of the experience the individual has had with the medication to date, not only the general risk associated with the medications. For example, the psychiatrist might note that one of the possible side effects of a medication is a tremor, that the individual indeed experienced a tremor, that the psychiatrist lowered the dose and that the psychiatrist and IDT determined that at lower dose the tremor is minimal and at that dose the benefits outweigh the risks. That | |

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| | | hypothetical presentation would then influence the cited dose range of the medication, the risk benefit statement, the presentation of information to the guardian for renewed consent, and so forth. Documentation need not be lengthy, and in likelihood it would simply summarize the details of the care already provided.<br><br>Renewals of MPs were not reviewed during the current monitoring visit, with the exception of the MP for Individual #250, reviewed under Provision J9. This MP had an adequate review of risk/ benefit on the basis of side effect experience to date.<br><br><u>Treatment Alternatives.</u> In the report for the April 2012 compliance visit the Monitoring Team recommended inclusion of discussion about treatment alternatives, per the provision language. In response, a section for discussion about alternative treatments was added to the MPs, effective 06/20/2012. That language was<br><br>"Alternative Treatments: IDT has discussed and agreed with implementation of non-pharmacological supports and treatment interventions discussed in PBSP. Psychiatric treatment is prescribed in conjunction with these interventions."<br><br>Ten of 21 (48%) of the MPs contained a section on treatment alternatives; 11 of 21 (52%) did not.<br><br>Among the MPs that did have a discussion of treatment alternatives, several had thoughtful presentation of those alternatives For example:<br>• For Individual #788: "Remeron is chosen over other antianxiety agents, like SSRI's or SNRIs, to prevent use of a separate sedative agent for insomnia. Benzodiazepines are not a good initial choice due to potential for tolerance, dependence, and cognitive side effects. If (the individual) achieves stability on Remeron Depakote will be tapered and discontinued due to (the Individual's) diagnosis of hepatitis B infection and upper extremity tremors."<br><br>However, eight of the ten (80%) contained only the standard language mentioned above. There was no individualization to the specifics of the person in question. What was needed instead was a summary of what the psychiatrist and IDT thought were meaningful clinical alternatives. Perhaps that could be another medication treatment, perhaps it would be a combination of medications, perhaps it would be a non medication approach such as CBT under the guidance of psychology or a communication program provided by habilitation or perhaps no treatment at all. The articulation of treatment alternatives need not be lengthy, but it must be made.<br><br>The provision is not now in substantial compliance due to a need to improve the presentation of both the risk/benefit analyses and the discussion of treatment alternatives. These are also needed for the Facility to achieve compliance with Provision | |

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<tr><td></td><td></td><td>item J14, since these two items are required elements for meaningful informed consent.</td><td></td></tr>
<tr><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 compliance visit, 239 of 492 (48%) of the individuals who lived at the Facility received support from psychiatry, including psychotropic medication.<br><br>Review of those individuals who took psychotropic medication showed that 13 of 239 (5%) received two or more psychotropic medications from the same clinical class, e.g. two antipsychotics. For the purposes of the SA, this was considered to be psychiatric intraclass polypharmacy. Another form of psychiatric polypharmacy was when individuals received a total of three or more psychotropic medications; at the time of the visit 70 of 239 (29%) received interclass polypharmacy.<br><br><u>Facility Level Review System:</u><br>Facility level review of polypharmacy took place at the monthly Polypharmacy Review Committee. Attendance at the meeting included psychiatrists and psychiatric assistants, PCPs, pharmacists, the lead psychologist, and other clinical staff.<br><br>The structure of the meeting was that each month there was a review of all individuals with intraclass polypharmacy. The format for the review was that each psychiatrist reviewed the status of individuals under his/her care, and provided an update on the efforts to reduce the polypharmacy. Each month, individuals with additional types of polypharmacy were also reviewed. These were for example, individuals with varying degrees of intraclass polypharmacy (total of three psychoactive medications, four psychoactive medications and so forth), and individuals taking certain classes of medications (benzodiazepines, anticonvulsants, anticholinergics and so forth). Use of anticholinergics and medications for cognitive decline were also reviewed. The monthly meetings were well structured and meetings were well attended.<br><br><u>Review of Polypharmacy Data:</u> For interclass polypharmacy, data were as follows:<br><br>
<table>
<tr><td></td><td>04/12</td><td>05/12</td><td>06/12</td><td>07/12</td><td>08/12</td></tr>
<tr><td>Three medications</td><td>57</td><td>58</td><td>57</td><td>58</td><td>56</td></tr>
<tr><td>Four medications</td><td>19</td><td>17</td><td>17</td><td>16</td><td>14</td></tr>
<tr><td>Five or more medications</td><td>1</td><td>2</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Total number of individuals</td><td>77</td><td>77</td><td>74</td><td>74</td><td>70</td></tr>
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<br>The above data is consistent with a continued decline in the use of polypharmacy at the</td><td>Substantial Compliance</td></tr>
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| | | Facility. The above table shows that there are no longer any individuals who receive five or more medications, and the number of individuals treated with four medications declined from 19 to 14. Reflected another way, the data showed that the average number of medications each individual in this group received in April 2012 was 3.27. In August 2012 that number had declined to 3.2. The number and percent of medicated individuals whose regimen consisted of three or more psychotropic medications has declined from 77of 241 (32%) at the last visit, to 70 of 239 (29%) during the current visit. In the last review the Facility was rated as in substantial compliance for this provision item. The reason for that is that there was a good structure in place for both individual reviews regarding the need for medication treatment (see Provision J3) and monthly Facility-wide reviews.<br><br>The Facility continued to use the PRC for issues that related to facility use of medication in a broad sense, including for clinical matters that went beyond the requirements of Provision J13. For example, during the review period, the PRC reviewed the cumulative anticholinergic load that individuals experience regardless of the chemical class or clinical indication of the medications that have anticholinergic effects. In another example, the PRC has expanded its review of individuals who have metabolic syndrome. The October meeting of the group included a review of individuals who had hyperlipidemia and took lipid lowering medications, and who also took psychiatric medications that could cause increases in lipid levels. The meeting of the PRC was attended by both psychiatrists and PCPs. It was a well-run meeting led by the Pharmacy Director and there was a case-by-case review of individuals' circumstances. That discussion contributed meaningfully to integrated care, since attendance included the medical specialists from medicine and psychiatry and that facilitated joint discussion about the best medication combinations.<br><br>A related discussion took place about the advantages of waist circumference over body mass index as an indicator for the status of metabolic syndrome. That too was a discussion that transcended the requirements of the SA for psychiatric polypharmacy monitoring. It represented an example in which the Facility used an interdisciplinary grouping of professionals to its fullest advantage via discussion of matters that were best discussed when all relevant disciplines were present. | |
| 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 | <u>Completion of rating scales:</u><br>The system in place for side effect monitoring at the Facility was for side effect screening to take place with both MOSES and DISCUS examinations to be done on a quarterly basis. The examinations were done by individuals' nurse case managers. The nurse case manager then presented the forms for review and signature to the psychiatrist (for the DISCUS) or psychiatrist and PCP (for the MOSES).<br><br>The Monitoring Team reviewed DISCUS and MOSES evaluations done for the 15 | Noncompliance |

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| | the individual's current status and/or changing needs, but at least quarterly. | individuals in Sample J2. For both MOSES and DISCUS evaluations, physician review was done in a timely manner for 13 of 15 (86%) of individuals. For the other two of 15 (14%) the reviews were done but there were delays for the review. In both these individuals, the screenings did not indicate acute medical problems.<br><br>The Monitoring Team has identified a need to use side effect monitoring when there is a change in status such as the initiation of a new medication or a change in medication dose. During the visit, the Monitoring Team reviewed with the Lead Psychiatrist the Facility's plans to do so. Such change of status examinations were included in a draft revision of the DADS Psychiatry Policy that was provided to the Monitoring Team for review. The draft policy directs that MOSES and DISCUS scales will be completed when:<br>1. A new psychotropic medication is initiated<br>2. DISCUS must be completed once a month for three months after a psychotropic medication is discontinued<br>3. MOSES and DISCUS will be completed within 10 to 14 days of a psychoactive medication dose change, as determined by the psychiatrist.<br><br>The Lead Psychiatrist informed the Monitoring Team that in preparation for anticipated changes, the Facility had newly started to do additional MOSES exams in response to changes in antipsychotic medications. Also, MOSES Screens were done when a dose change is made by the neurologist in the seizure clinic. This was done whether or not the anticonvulsant was prescribed as a dual purpose medication or for seizure alone.<br>The Facility acknowledged that there was not yet a full system in place to ensure that side effect monitoring was done in response to individuals' changing needs, primarily around a change in medication.<br><br><u>Training for Administration of the MOSES and DISCUS side effect screens:</u><br>During the visit the Monitoring Team met with representative of the Nursing Department to review QA for side effect screening, including the training nurse case managers receive for test administration. The training provided to the nurse case managers was provided by the nurse educators, who in turn participated in several-day training in Austin in 2006. The course was given by the author/developer of both side effect tools, and included in-vivo administration sessions and videotape reviews of test administration and example cases. Local training is facilitated by videotape and written materials prepared by the author.<br><br><u>Facility level review:</u><br>The Monitoring Team requested and received a listing of all individuals who had elevated DISCUS ratings and a listing of all individuals diagnosed with tardive dyskinesia. The Monitoring Team confirmed that the diagnosis of dyskinesia was included in the APL for those individuals. The Monitoring Team noted that many of those individuals continue to receive psychotropic medications that can worsen dyskinesia over time.; the Facility | |

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| | | should implement a process to monitor this and periodically re-assess risk versus benefit.<br><br>Monitoring Team compliance ratings:<br>Based on the review of the 15 individuals in Sample J2, there has been an improvement in the timely review of MOSES and DISCUS examinations. In the self-rating the Facility acknowledged the need to improve the overall QA effort for tracking completion and review of side effects screening for psychotropic and non-psychotropic medications. The Monitoring Team concurs.<br><br>In conclusion, there have been improvements but there remains a need for better QA monitoring, and a process for change of status evaluations is not yet in place. | |
| 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. | Psychiatrists wrote a 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 updates that were completed prior to annual ISP meetings.<br><br>The sections of the MP were:<br>• Name of the medication<br>• Psychiatric Diagnosis<br>• Rationale for treatment<br>• Target psychiatric symptoms<br>• Symptoms to be monitored<br>• Timeline for expected results<br>• Risk/Benefit Assessment<br>• Treatment Alternatives<br><br>The Monitoring Team reviewed all new psychotropic medication initiated during the review period. There were 21 such medications for 18 individuals. These were Sample J5. Findings were as follows:<br>• Name of the medication and psychiatric diagnosis: MPs contained both the name of the medication and the individual's psychiatric diagnosis or diagnoses in all 21 of 21 (100%) of the MPs.<br>• Rationale for the treatment: The Monitoring Team reviewed the information to see that the purpose of the medication was clear and the medication was reasonably linked to the clinical diagnosis. The Monitoring Team found that to be the case for 17 of 21 (80%) of the MPs.<br>• Target psychiatric symptoms: The psychiatric targets of treatment were typically broad categories of symptoms, such as delusions, depression and so forth. The Monitoring Team reviewed MPs to make sure that at least one of the targets clearly related to the listed psychiatric diagnosis. In 15 of 21 (71%) the | Noncompliance |

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| | | Monitoring Team found that the category of symptoms related to the diagnosis in question.<br>• Symptoms to be monitored: The symptoms provided were most often more detailed examples of the broader categories listed as target psychiatric symptoms. The MPs did not, however, spell out the details of the behavioral monitoring that would be provided by the psychologists.<br><br>During previous visits the Facility indicated that it would base symptom rating on personal observations by the psychologist, supported by information provided to the psychologist by DSPs 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. For the proposed system to be viable it needed to clearly state exactly what was being rated; behavioral definitions of the kind used frequently in the PBSP for challenging behaviors needed to be developed. In addition, since many symptoms were to be rated on a scale for severity or frequency, the ratings on those scales needed to be defined. None of these were outlined in the MPs for proposed treatments, nor were they present for ongoing monitoring of psychiatric treatments already in place (see discussion under Provision J3).<br><br>During the compliance visit, the Monitoring Team discussed these matters with the Facility. The Monitoring Team was informed that in the future, the details for monitoring plans would be included in PBSP revisions (or perhaps PBSP addenda for new medications). If this is done, perhaps this entry in the MP will be superseded and unnecessary.<br>• Timeline for expected results: Provided in 21 of 21 (100%) of the cases.<br>• Risk Benefit Analysis: All MPs listed provided a risk benefit analysis and that was positive. As outlined in more detail under Provision J10, however, many of the risk benefit analyses were not sufficiently individualized for the chosen medication and the individual.<br>• Treatment Alternatives: This section had been newly added. That was a positive step in response to a recommendation made during the previous compliance visit. However, as was outlined in more detail under Provision J10, only 10 of 21 (48%) of the MPs had a discussion on treatment alternatives, and many of those 10 contained a standardized statement that was not individualized for the medication that was chosen and for the individual.<br><br>Overall the Facility has moved forward with refinements of MPs, the primary focus of this provision item. Continued efforts are needed in the areas of risk/benefit analyses, treatment alternatives, and symptom monitoring. | |

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| J14 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks. | The consent form currently in use at the Facility provided the following information:<br>• Diagnosis<br>• Medication for approval and medication dose ordered<br>• Recommendations from consulting psychiatrist (if applicable)<br>• Pertinent side effects (discussed with guardian/director)<br><br>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.<br><br>A general indication was provided on the form in which the Legally Authorized Representative (LAR) acknowledged that explanations about the medication were given in simple, nontechnical language and included:<br>• A description of any benefits to be expected<br>• Disclosure of any appropriate alternative procedures that might be advantageous to the person served as well as the potential risks and benefits associated with those alternatives<br>• Possible adverse side effects/risk of the prescribed medication, per drug effect monographs provided<br><br>Guardians were provided with a copy of the MP that contained considerable information about the medication including information on:<br><br>Each MP contained:<br>• Name of the medication<br>• Psychiatric Diagnosis<br>• Rationale for treatment<br>• Target psychiatric symptoms<br>• Symptoms to be monitored<br>• Timeline for expected results<br>• Risk/Benefit Assessment<br>• Treatment Alternatives<br><br>In the previous review the Monitoring Team noted that the consent process for medications had improved considerably. Consent is now obtained by the treating psychiatrist and the guardian is provided with copies of both the revised Facility consent form and the MP that provided additional details about the proposed use of the medication. During the last visit the Monitoring Team encouraged the Facility to focus on a number of areas that needed improvement. The current status of these was:<br>• PBSPs with all needed information on new medication were provided for four of 21 (19%) new medications. However, PBSP revisions were not yet in place for | Noncompliance |

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| | | the remaining medications and HRC reviews were not provided for any of the medications. This matter was explored during the visit; the Monitoring Team was given listings of individuals and medications that were reviewed during HRC sessions, but the actual HRC review sheets were not received. These were needed, since the Monitoring Team had previously noted that the risk vs. risk section and other information provided to the HRC sometimes addressed the overall treatment program, not the medication being proposed.<br>• The MP form has now been modified, to include a statement that treatment alternatives were discussed. However, as is outlined under Provision J10, the presentation needs to be more individualized.<br>• Side effect information in the PBSP was much improved, as discussed under Provisions J3 and J13. However, as identified in the Facility Self-Assessment, 11 of 20 (55%) of the new MPs reviewed had side effects listed on the MPs that did not match the consent forms. The underlying difficulty needs to be resolved (see Provision J13). | |
| J15 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder. | No Neurology-Psychiatry Clinic was scheduled during the visit of the Monitoring Team, so the Clinic could not be observed.<br><br>Materials reviewed for assurance of compliance with Provision J15 included:<br>• A review of dual purpose anticonvulsant medications used for psychiatric indications, for neurological indications, and dual purpose medications used for both psychiatric and neurological indications<br>• Review of Neurology and Psychiatry Clinic notes for five individuals who took dual purpose medications (Sample J6)<br>• Review of summary notes by a psychiatry assistant for all individuals reviewed during the September 19, 2012 Neurology-Psychiatry Clinic<br>• Discussion with the Lead Psychiatrist regarding MOSES tracking for side effects<br><br>Review of the pharmacy tracking for anticonvulsant use showed that there were 24 individuals who received dual purpose medications. Twenty-three received one such medication and one individual took two. Neurology and Psychiatry Clinic notes were reviewed for five of 24 (20%) of those individuals (Sample J6). The review showed that in both Neurology and Psychiatry Clinic there was appreciation of the use of the medication for both purposes and that appropriate data such as drug levels and dose changes were reported.<br><br>The Monitoring Team also reviewed whether anticonvulsants in the sample of PMRs attended by the Monitoring Team (Sample J1) were properly categorized in the pharmacy listing for purpose of anticonvulsant use. This was because during the last compliance visit the Monitoring Team had noted an inaccuracy in tracking and suggested | Substantial Compliance |

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| | | vigilance to this matter. In the current review of PMR discussions, there were no inaccuracies.<br><br>During the visit, the Lead Psychiatrist informed that Monitoring Team that the Facility has started to do MOSES reviews whenever anticonvulsant doses were changed in the Neurology Clinic, not only for individuals who received dual purpose medications, but for all anticonvulsant dose changes. Results were provided to the PCP and also to psychiatrists, for all individuals under their care. This was a positive development. In many cases where anticonvulsants have been used for many years, psychotropic effects of those medications – positive and negative – become apparent only when the dose is changed and behavioral effects follow. For that reason, it is very helpful for the psychiatrist to be aware of changes in anticonvulsant medication even when the medication is formally prescribed only for epilepsy.<br><br>Taken together, the increased attention to tracking the behavioral effects of all anticonvulsant medications was positive, and was an example of well integrated care.<br><br>On the basis of the review of the documents listed above and on the basis of the discussions between the Monitoring Team and the Lead Psychiatrist about the steps taken in regard to side effect monitoring, the Monitoring Team found that coordination between psychiatry and neurology remained strong. The Facility remained in compliance with this provision item. | |

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

1. Use of the new medical/dental restraint form should be reviewed, in order to develop consistent practices for entry of vital signs and other aspects of nurse monitoring onto that form and onto IPNs. Once these practices are established, nurses should be provided training on the use of the new medical/dental restraint for medical restraints. (Provision J4)
2. Case formulations in CPEs should be improved to present a better case synthesis. (Provision J6)
3. When diagnoses are changed or updated, the following annual update of the CPEs should include a summary of the reasons for the change and the diagnostic justification for the new diagnosis. (J6)
4. The Facility should complete a procedure for use of the Reiss screen during clinical change of status evaluations. (Provision J7)
5. Psychologists should increase their contribution to the combined case formulations. (Provision J8)
6. Discussion of treatment alternatives and risk benefit analyses should be individualized for the medication and individual in question. (Provision J10)
7. The Facility should develop a procedure for doing side effect screen after a change in medication dose. (Provision J12)
8. Differences between presentations of psychotropic side effect information in MPs, medication consents and PBSPs should be resolved. (Provisions J3, J13, J14)
9. The Facility should implement a process to monitor administration of dopaminergic agents to individuals known to have tardive dyskinesia and should periodically re-assess risk versus benefit. (Provision J12)

10. PBSP revisions (or PBSP addenda) for new medications should be completed in a timely manner. (Provisions J3, J8, J9, J13, J14)

The following are offered as additional suggestions to the Facility:

1. The Monitoring Team noted that the Lead Psychiatrist was carrying essentially the same caseload as other staff psychiatrists, despite the many responsibilities inherent in her work as the Lead psychiatrist. The Facility might consider re-assignment of some of the individuals under her care to the other psychiatrists, to allow her the needed time to attend to the clinical/administrative responsibilities inherent to the role of Lead Psychiatrist.

| SECTION K: Psychological Care and Services | |
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| 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:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment 9/24/2012<br>2. DSSLC Action Plans 9/24/2012<br>3. DSSLC Presentation Book for Section K<br>4. Positive Behavior Support Committee meeting minutes - 3/7/2012 – 9/5/2012<br>5. An alphabetical list of individuals, including the type/name of their most recent psychological assessment and update, and the date on which the assessment and update occurred.<br>6. Training materials and data from Behavior Analysis Research Clinic (BARC) training<br>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 the following Individuals: Individual #33, #35, #50, #119, #127, #141, #216, #231, #238, #240, #305, #306, #317, #336, #373, #412, #483, #537, #605, #616, #619, #620, #629, #631, #740, #781, #790,and #799<br>**People Interviewed:**<br>1. Randy Spence, MS – Director of Behavior Services<br>2. Jill Wooten, MS, BCBA – Psychologist<br>3. Katy Acheson, MS, BCBA – Contract Psychologist<br>4. Brian Almejo, MS – Psychologist<br>5. Matt Grennell, MS, BCBA - Psychologist<br>6. Robert Schecter, MS, LPC – Psychologist<br>7. Ira Adams, PhD – Psychologist<br>8. Laura Dittlinger-Harper, BCBA - Consultant<br>9. Approximately 25 direct care staff in the following residences and day treatment areas: Residence 512, 502B, 502C, 502D, 502D, 508A, 522A, 522B, 522C, 522D, 523B, 523C, 523D, 525A, and525B, as well as training area ICD 121, ICD 124, and ICD 128.<br>**Meeting Attended/Observations:**<br>1. Positive Behavior Support Committee – 10/10/2012<br>2. Restraint Reduction Committee – 10/10/2012<br>3. BARC Training – 10/10/2012 and 10/11/2012<br>4. Observations were conducted in the following residences and day treatment areas: Residence 512, 502B, 502C, 502D, 502D, 508A, 522A, 522B, 522C, 522D, 523B, 523C, 523D, 525A, and525B, as well as training area ICD 121, ICD 124, and ICD 128. |
| | **Facility Self-Assessment:**<br>At the time of the site visit, DSSLC reported that Provisions K.2, K.3 and K.8 were in substantial compliance |

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| | with the Settlement Agreement. The Monitoring Team was in agreement with the Facility on substantial compliance for Provisions K.2 and K.3. In regard to Provision K.8, however, the Facility failed to provide documentation to support that Provision K.8 remained in substantial compliance. Without documentation, the determination of continued substantial compliance could not be made.<br><br>In a review of the Self-Assessment completed by the Facility, one issue was notable. In several Provisions, the factors being monitored and reported by DSSLC were different than those targeted by the Settlement Agreement and Monitoring Team for the same Provision. For example, in Provision K.4, the Facility was monitoring and reporting on external peer review of progress notes and data on inter-observer agreement. Although these areas did reflect targets of the Monitoring Team as well, the Facility did not demonstrate any data regarding issues such as input from DSP staff. This was particularly relevant as the Monitoring Team had consistently expressed the need in regard to participation of DSP staff in treatment development and monitoring across previous site visits.<br><br>Another example involved Provision K.5. This Provision focuses upon intelligence and adaptive behavior testing, the interpretation of those testing results, and specific characteristics of the functional assessment. The Facility Self-Assessment, however, reflected monitoring of only of the functional assessment. It was again noteworthy that the Monitoring Team had consistently pointed out the need in regard to intellectual and adaptive testing over previous site visits.<br><br>A final example involved Provision K.9. This Provision includes specific requirements for approvals and consents, timeliness of PBSP implementation, and specific requirements for PBSP content. The Facility Self-Assessment, however, focused almost entirely upon timeliness of PBSPs. In this case, the Facility had focused upon an area of previous poor performance, the timeliness of PBSPs. The assessment findings reported by the Facility reflected substantially greater timeliness than the findings made by the Monitoring Team using Facility tracking data. Therefore, the accuracy of the Facility's Self-Assessment efforts was brought into question.<br><br>The Facility Action Plans, the strategies for addressing weaknesses identified, often mirrored the limitations found in the Self-Assessment. Additionally, however, the Action Plans at times reported plans as complete that the Monitor continued to identify as inadequate. For example, the Facility reported that efforts for increasing timeliness of PBSPs were complete when the Facility's data reflected substantial delays in implementing PBSPs.<br><br>Achieving substantial compliance with the Settlement Agreement requires that a Facility develop, implement, and maintain a system for measuring performance. Furthermore, this system for measuring performance must be comprehensive and accurate. At the time of the current site visit, there remained a need for further improvement in implementing such a system. |
| | **Summary of Monitor's Assessment:**<br>Observations, interviews, and record reviews were conducted on-site at DSSLC from 10/8/2012 through 10/12/2012. Record reviews continued off-site following the site visit. Based upon information gathered |

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| | during the current site visit, it was apparent that the Facility had achieved substantial compliance for Provisions K.2 and K.3. Although the Facility had indicated that substantial compliance had been achieved for Provision K.8, the Facility did not provide the data necessary to support this claim.<br><br>It was quite evident that the Facility had invested considerable effort into improving services and maintaining previous success. For example, the Facility continued to demonstrate improvement in the quality of both functional assessments and PBSPs. Progress also continued in relation to the ensuring psychology staff were certified in applied behavior analysis. There was also ample evidence to support that the internal and external peer review at DSSLC continued to be comprehensive and effective.<br><br>Unfortunately, there were areas in which the Facility was unable to achieve progress. There was little evidence presented to indicate that the Facility was improving efforts to measure the reliability of data or ensure that PBSPs were implemented consistently and correctly. The Facility also continued to experience difficulty in implementing PBSPs in a reasonable amount of time.<br><br>Most striking, however, was the difficulty demonstrated by the Facility in measuring performance, determining progress, and organizing data to support claims of progress. Without a sophisticated system to monitor progress and coordinate data, the Facility will continue to experience difficulty in achieving substantial compliance with the Settlement Agreement. |

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<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><u>Historical Perspective</u><br>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. In April 2012, 55% of the Behavior Service were BCBAs, an increase of 31%.<br><br><u>Current Site Visit</u><br>During the current site visit, Facility records regarding Psychology Department staff were reviewed. These records reflected that eight of 19 staff (42%) were board certified as a behavior analyst. Of the remaining 11 staff, seven (64%) were actively pursuing board certification. Therefore, it was determined that 79% of the current Psychology Department staff either possessed or were actively pursuing board certification.<br><br>
<table>
<tr><th></th><th>3/2010</th><th>4/2012</th><th>10/2012</th></tr>
<tr><td>Percent of staff who were BCBAs</td><td>24%</td><td>55%</td><td>42%</td></tr>
<tr><td>Percent of staff lacking BCBA who were pursuing board certification</td><td>23%</td><td>90%</td><td>64%</td></tr>
<tr><td>Percent of staff who were BCBAs or were pursuing board certification</td><td>50%</td><td>75%</td><td>79%</td></tr>
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| | | Although the total percentage of Psychology Department staff with board certification had dropped in comparison with previous site visits, evidence reflected this decrease to be the result of attrition and routine personnel changes, and that staff were continuing to pursue certification. Overall data indicated that the Psychology Department at DSSLC continued to emphasize the necessity of board certification for the majority of eligible departmental staff. | |
| K2 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility. | At the time of the site visit, DSSLC employed a full-time director of Behavior Services, Joseph Randall Spence. Mr. Spence had extensive experience in the field of intellectual and developmental disabilities. 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. | Substantial Compliance |
| K3 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs. | DSSLC, at the time of the current site visit, continued to implement the internal and external peer review process noted during previous visits. The Facility maintained a policy for internal peer review that reflected accepted practice. A board certified behavior analyst coordinated the internal peer review committee. A review of committee minutes and discussions with staff revealed active application of a sound peer review model. In addition, documentation reflected that individuals with PBSPs were reviewed on at least an annual basis.<br><br>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.<br><br>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. | Substantial Compliance |

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<tr><th>Area of Competency</th><th>Percentage Achieved 9/2010</th><th>Percentage Achieved 4/2012</th><th>Percentage Achieved 10/2012</th></tr>
<tr><td>Competency 1</td><td>78</td><td>90</td><td>98</td></tr>
<tr><td>Competency 2</td><td>50</td><td>82</td><td>88</td></tr>
<tr><td>Competency 3</td><td>75</td><td>91</td><td>92</td></tr>
<tr><td>Competency 4</td><td>52</td><td>90</td><td>97</td></tr>
<tr><td>Competency 5</td><td>51</td><td>92</td><td>89</td></tr>
<tr><td>Competency 6</td><td>35</td><td>96</td><td>100</td></tr>
<tr><td>Competency 7</td><td>33</td><td>91</td><td>96</td></tr>
<tr><td>Competency 8</td><td>78</td><td>95</td><td>96</td></tr>
<tr><td>Total of all Competencies</td><td>55</td><td>94</td><td>94</td></tr>
</table>
<br>Based upon this comparison, training and review practices had been enhanced, and behavior assessments and interventions were improved. Although there were areas in which the PBSPs did not yet meet substantial compliance with the SA, the peer review process was effective in improving the PBSPs. Based upon the data obtained during the most recent site visit, peer review was successful in meeting substantial compliance with the SA.</td><td></td></tr>
<tr><td>K4</td><td>Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have</td><td><u>Historical Perspective</u><br>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.<br><br>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. 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.<br><br>During the April 2012 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</td><td>Noncompliance</td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>substantially changed.</td><td>the response to treatment. A 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.<br><br><u>Current Site Visit</u><br>At the time of the current site visit, the Facility reported that revised data sheets and data collection procedures had recently been implemented. Due to the recent nature of the change, only a limited sample of examples was available. Therefore, the review process included both old and new data processes and forms.<br><br>A sample of 18 records was selected for review. The Facility had been asked to provide records for individuals meeting one of the following conditions; 1) the PBSP was terminated due to successful completion of the intervention, 2) the PBSP was continued due to progress achieved by the intervention, or 3) the PBSP was revised due to a lack of success. This sample was furthered narrowed to include no more than one PBSP for any member of the Psychology Department. If a staff member was represented more than once in the provided records, only the most recent PBSP was selected for inclusion in the sample.<br><br>The table below reflects the results from the current site visit review.<br><br>
<table>
<tr><th></th><th>Baseline</th><th>4/2012</th><th>10/2012</th></tr>
<tr><td>Targeted behavior data collection sufficient to assess progress.</td><td>0%</td><td>75%</td><td>89%</td></tr>
<tr><td>Replacement behavior data collection sufficient to assess progress.</td><td>0%</td><td>75%</td><td>44%</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>50%</td><td>100%</td></tr>
<tr><td>Targeted behaviors graphed sufficient for decision-making.</td><td>60%</td><td>75%</td><td>89%</td></tr>
<tr><td>Replacement behaviors graphed sufficient for decision-making.</td><td>0%</td><td>75%</td><td>44%</td></tr>
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<br>Information gained from the record sample reflected that DSSLC had achieved improvement in some areas of data collection and presentation. In 16 of 18 records (89%) data collection regarding behaviors targeted for reduction was sufficient to allow the Facility to determine whether the PBSP was successful. In addition, in 16 of 18</td><td></td></tr>
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| | | records (89%), data were graphed sufficient for determination of programmatic progress. In 18 of 18 records (100%), progress notes clearly reflected that target behaviors were assessed for progress individually or by functional class. This would help to ensure that progress or lack of progress on a single target would not be allowed to hide or overshadow the response to treatment for the remaining targets.<br><br>Not all areas regarding data collection and presentation reflected progress. In some areas, such as interobserver agreement, there was no progress achieved. In other areas, however, the Facility had failed to maintain previous achievements.<br><br>Replacement Behavior Data Collection. Data collection for replacement behaviors, those behaviors that were targeted for increase in order to replace undesired behaviors, relied heavily upon partial-interval data collection procedures. In partial-interval data collection, if a targeted behavior is displayed at any point during a predetermined length of time (an interval), that interval is scored as an occurrence of the behavior. If the behavior is not displayed during the interval, the interval is scored as a non-occurrence. When using partial-interval data collection, it is important to limit the length of the interval. If the interval is too long, the behavior may be displayed several times during the interval. When this happens, despite the number of displays, data collection reflects only a single occurrence, potentially creating an underestimate of the targeted behavior frequency.<br><br>When partial-interval data collection was used at DSSLC, the length of the interval was always one hour. PBSPs explained that interval data collection had been selected due to the potentially high frequency of displays of the replacement behaviors and the difficulty that high rates of behavior would introduce for staff collecting data. Therefore, rather than shorten the interval or select a more appropriate data collection procedure, DSSLC opted to use an interval-based data collection system with a standard one-hour interval; although use of such a system can be appropriate and practical, intervals that allow a large number of frequent responses to occur within a single interval are likely not to be sensitive to changes in the occurrence of the behavior; thus, programs that are actually being effective in gradually reducing occurrence of the target behavior may be interpreted as ineffective, as the number of intervals with the behavior occurring may not change although the frequency within intervals is reduced. Decisions on length of interval should be individualized and selected so as to be both practical and sensitive to change in frequency of the behavior.<br><br>Data Reliability. One area in which no progress had been achieved over baseline conditions involved Interobserver Agreement (IOA) data collection and reporting. For some individuals, problems encountered in staff completion of data collection was mentioned in the narrative of progress notes. On several progress notes, the percentage | |

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| | | of data forms completed by staff was reported. It was not indicated, however, whether the documented percentage reflected the number of data forms completed correctly or just the number of forms staff had submitted. In none of sampled records, however, was IOA reported or used in the assessment of treatment response.<br><br>Replacement behaviors graphed sufficiently for decisions. As noted above, DSSLC relied heavily upon partial-interval data collection for behaviors targeted for increase. In addition to the risk of underestimating the frequency of those behaviors, the use of interval data introduced problems in the graphing of data.<br><br>In relation to PBSPs, one purpose of graphing data is to allow for comparisons between behaviors targeted for increase and behaviors targeted for decrease. Behaviors targeted for increase typically are socially-desired behaviors that can replace behaviors targeted for decrease because they share the same function or goal. Data graphs should be able to depict trends in data so that it can be determined that the behaviors targeted for increase are actually increasing at the same time that undesired behaviors are decreasing.<br><br>In order for graphs to achieve the purpose of comparing changes in behavior, it is important that data be as accurate as possible and that the measures of the two targets reflect the same data collection methods. As noted above, the use of partial-interval data collection for replacement behaviors increased the probability that the replacement behavior data would be inaccurate due to undercounting displays of the replacement behaviors. In addition, although DSSLC used partial-interval data for replacement behaviors, all behaviors targeted for decrease were measured using total frequency data. Therefore, the ability of data graphs to facilitate the determination of treatment efficacy was impeded by the use of inaccurate replacement behavior data and by attempted comparisons between frequency and partial-interval data.<br><br>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 continued to achieve 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.<br><br>\| \| 1/2010 \| 4/2012 \| 10/2012 \| | |

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| 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% | 50% | 44% |
| Input from direct care staff is solicited and documented | 0% | 0% | 0% |
| Modifications to the PBSP reflect data-based decisions | 0% | 38% | 78% |
| Criteria for revision are included in the PBSP | 0% | 100% | 100% |
| Progress evident, or program modified in timely manner (3 Months) | 0% | 38% | 89% |

Of the 18 records reviewed, 14 (78%) reflected reliance upon data to support treatment decisions. In the majority of these 14 records, the Individual was making progress toward the treatment objective and no revision to the PBSP was necessary. The records also reflected, however, that the Facility was not consistently quick to respond when data reflected the potential need for a revision to the PBSP. For example, Individual #33 experienced a spike in physical aggression in May 2012. Although physical aggression rates remained elevated for several months, Facility documentation did not reflect recognition that assessments should be reviewed or that revisions to the PBSP should be considered.

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, the Facility was much better prepared to provide an adequate review of behavioral and psychiatric interventions. In some areas, however, the Facility had not achieved the necessary progress.

Data review is conducted by a BCBA. Documentation obtained during the current site visit revealed that treatment monitoring was conducted by a BCBA for 44% of the PBSPs in the sample. This reflected an improvement over baseline, but was a slight decline in comparison with the previous site visit. This decline, however, was likely due to routine personnel changes rather than a failure of the facility.

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

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| | | for any of the 18 PBSPs.<br><br>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 treatment. | |
| K5 | Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention. | 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.<br><br>Based upon a review of tracking data, it appeared that some confusion existed at DSSLC regarding Psychological Assessments. As requested by the Monitoring Team, the Facility was to include a document that provided, "An alphabetical list of individuals, including the type/name of their most recent psychological assessment and update, and the date on which the assessment and update occurred." Although the Document Request included this document, the document listed only the most recent functional assessment. The functional assessment, titled Psychological/Functional Assessment, at times presented intellectual and adaptive assessment scores, but did not provide a full interpretation of those results. DSSLC had developed and implemented a separate document for reporting and interpreting intellectual and adaptive testing results, but neither this document nor the intellectual and adaptive testing was provided in response to the request.<br><br>Due to the lack of data provided, additional records and documents were reviewed in an attempt to obtain the necessary information. The only evidence regarding Psychological Assessment compliance was included in the Facility Self-Assessment. This evidence consisted of a single statement that, "145 individuals of 494 (30%) have current psychological evaluations within the past five years." There was no indication of how many of the psychological evaluations had been completed within the past year, whether the reports included intellectual testing completed within five years, or whether the reports included adaptive testing completed within the past year.<br><br>In the sample of 18 records, intelligence test scores were reported for four individuals (22%). Three of those four records (17% of the sample) reflected intelligence testing | Noncompliance |

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| | | within the past 5 years. Two of the 18 records (11%) included adaptive behavior assessment scores; in both cases the testing had been completed within the previous year. | |

| | 3/2010 | 4/2012 | 10/2012 |
|---|---|---|---|
| A Psychological Assessment had been completed. | 0% | 4% | 30%* |
| The Psychological Assessment was less than one year old | 0% | 4% | Could not determine |
| The Psychological Assessments contained findings from an intellectual test administered within the previous five years. | 0% | 0% | Could not determine |
| The Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment. | 9% | 0% | Could not determine |

- As reported in the self-assessment

The assessment of behavioral function is an essential component of effective behavior change and requires more than the completion of a screening tool, interview or series of observations. Determining the function of a behavior is an empirical process that begins with general observation and progresses with increasing control and focus through screenings, interviews and formal observations until a specific hypothesis regarding the function or purpose of the undesired behavior is developed. An acceptable functional assessment or functional analysis does not produce a series of ambiguous statements regarding the function of the undesired behavior. Rather, the product of the assessment process is a specific statement regarding the most likely function of the behavior or an indication of how ambiguous findings will be resolved. Without additional investigation, ambiguous statements are indicative of an assessment process that has not been completed.

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 April 2012 DSSLC site visit. Due to the recent nature of the revision, only five functional assessments were available for review at the time of that site visit.

At the time of the current site visit, the Facility had more fully implemented the changes

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| | | to the functional assessment procedures. A sample of 18 records was selected for review. The Facility had been asked to provide records for individuals meeting one of the following conditions; 1) the PBSP was terminated due to successful completion of the intervention, 2) the PBSP was continued due to progress achieved by the intervention, or 3) the PBSP was revised due to a lack of success. This sample was furthered narrowed to include no more than one PBSP for any member of the Psychology Department. If a staff member was represented more than once in the provided records, only the most recent PBSP was selected for inclusion in the sample. | |

| | 1/2010 | 4/2012 | 10/2012 |
|---|---|---|---|
| Assessment or review of biological, physical, and medical status | 0% | 100% | 94% |
| Review of personal history | 0% | 100% | 100% |
| A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis | 0% | 100% | 89% |
| The process or tool utilizes both direct and indirect measures | 0% | 100% | 83% |
| Identification of setting events and motivating operations relevant to the undesired behavior | 0% | 100% | 83% |
| Identification of antecedents relevant to the undesired behavior | 0% | 100% | 83% |
| Identification of consequences relevant to the undesired behavior | 0% | 100% | 89% |
| Identification of functions relevant to the undesired behavior | 0% | 100% | 83% |
| Summary statement identifying the variable or variables maintaining the target behavior | 0% | 100% | 89% |
| Identification of functionally equivalent replacement behaviors relevant to the undesired behavior | 0% | 100% | 72% |
| Identification of preferences and reinforcers | 0% | 20% | 83% |

Ratings were lower on most items for the current site visit in comparison with the previous site visit, During the previous site, however, the sample size was very small; only five records. Sample size differences, especially with small samples, make comparisons difficult. It is important to note, however, that even if there was a decline in

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| | | status, the ratings during the current site visit reflected very positive performance for this part of the Provision.<br><br>Based upon a review of the 18 functional assessments, it was evident that considerable improvement had been achieved and maintained by DSSLC. The latest format for functional assessments 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.<br><br>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.<br><br>During the September 2010 site visit, DSSLC demonstrated considerable difficulty in incorporating the signs and symptoms of mental illness into the functional assessment process. Improvement was noted March 2011, but in most cases functional assessments did not integrate the objective assessment of mental illness into the evaluation process or include behaviors correlated with mental illness in the functional assessment process. Although considerable effort by DSSLC to resolve the weakness was noted during the 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 April 2012 site visit. Much of the revision addressed limitations in the integration of mental health assessment with the assessment of environmentally-based behaviors. In April, 2012, however, only five examples had been available for review, but 18 were reviewed at the current visit. | |

| | 3/2010 | 4/2012 | 10/2012 |
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| The assessment process included screening for psychopathology, emotional, and behavioral issues. | 0% | 40% | 94% |
| The assessment process included differentiation between learned and biologically based behaviors. | 0% | 40% | 74% |

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| Identification of behavioral indices of psychopathology | 0% | 40% | 74% |
| Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities | 0% | 60% | 94% |

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

The 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 procedures and conforms to accepted standards of practice. The behavior assessment element of the functional assessments reviewed reflected both competence and diligence in meeting these goals. The integration of mental health issues into the functional assessment, however, although much improved, did not consistently meet expectations.

For example, Individual #141 was provided a diagnosis of Attention Deficit Hyperactivity Disorder NOS and Stereotypic Movement Disorder. In the differentiation between learned behaviors and symptoms of mental illness, the functional assessments indicated only that mental illness could limit the development of desired behaviors, and that the environment might provide more efficient reinforcement for undesired behaviors. In essence, this portion of the functional assessment, rather than providing answers necessary for effective intervention, only illustrated that questions remained regarding why the undesired behaviors were displayed. The more appropriate approach would have been to utilize the functional assessment process to establish to the greatest extent possible the role of both the mental illnesses and the environment in maintaining the undesired behaviors.

As reported in Provision J7, the Facility had re-screened 15 individuals who had positive Reiss Screens noted in the report of the April 2012 compliance visit, with only two showing positive screens. Internal review by the Facility showed that in some cases, adequate training may not have been provided to the individuals who gave and scored

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<tr><td></td><td></td><td>the screens. In order to assure that Reiss Screens had the highest quality, the Facility has decided to provide proper training on test administration, and to start the process anew for all 254 individuals who needed the screening.<br><br>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 lack of intellectual and adaptive assessments, as well as the use of those assessments in identifying needs requiring intervention for individuals 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. Further conclusions could not be reached due to the circumstances describe in Provision K.5 concerning the lack of relevant documentation.<br><br><table><tr><th></th><th>Baseline</th><th>4/2012</th><th>10/2012</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><td>Could not determine</td></tr><tr><td>For newly admitted individuals, psychological assessments are conducted within one month.</td><td>0%</td><td>0%</td><td>Could not determine</td></tr></table></td><td>Noncompliance</td></tr>
<tr><td>K8</td><td>By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided</td><td><u>Historical Perspective</u><br>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>
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<tr><td></td><td>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.<br><br>At the time of the April 2012 site visit, DSSLC reported that 23 individuals were receiving counseling through the Behavior Services department at DSSLC. 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.<br><br><u>Current Site Visit</u><br>At the time of the current site visit, DSSLC submitted material on approximately 10 individuals receiving in counseling services. This materialdid not include information needed to permit an assessment of the status of counseling programs. Much of this document consisted of partially scanned data graphs, progress notes, and treatment plans. For example, for several individuals it appeared that the left two inches of every page had been cut off. The same was true of many data graphs, although there were also examples where other portions of the graphs had been cropped off as well. As most pages included no identifying information, it was unclear as to whom those pages referred.<br><br>
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<tr><th></th><th>1/2010</th><th>4/2012</th><th>10/2012</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>Could not determine</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>100%</td><td>0% Could not determine</td></tr>
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<tr><td>Services are goal directed with measurable objectives and treatment expectations.</td><td>0%</td><td>100%</td><td>Could not determine</td></tr>
<tr><td>Services reflect evidence-based practices.</td><td>0%</td><td>100%</td><td>Could not determine</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>100%</td><td>Could not determine</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>Could not determine</td></tr>
<tr><td>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.</td><td>0%</td><td>0%</td><td>Could not determine</td></tr>
<tr><td>Service identified in ISP and, if applicable, PBSP.</td><td>0%</td><td>100%</td><td>Could not determine</td></tr>
<tr><td>Staff who provide therapeutic interventions are qualified to do so through specialized training, certification, or supervised practice.</td><td>0%</td><td>100%</td><td>Could not determine</td></tr>
<tr><td>Staff who assist in therapy, or who supervise homework or milieu activities, receive training and monitoring from qualified therapists.</td><td>0%</td><td>100%</td><td>Could not determine</td></tr>
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<br>There were suggestions in the partially scanned documents that the previous counseling practices had been continued. Without clear documentation, however, it was not possible to determine that the Facility had successfully maintained previous progress. Therefore, the Facility could no longer meet the criteria for substantial compliance.
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<tr><td>K9</td><td>By six weeks from the date of the individual’s assessment, the Facility shall develop an individual</td><td><u>PBSP Approval and Consent</u><br>During the current site visit, documentation submitted by the Facility for tracking PBSP implementation was used to determine if behavior interventions were implemented in a</td><td>Noncompliance</td></tr>
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| | 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. | timely manner and if the necessary approvals were obtained for those behavior interventions. The documentation reflected that 219 PBSPs had been submitted for review and approval since 5/1/2012. For these 219 PBSPs, there were indications of frequent delays in approval and implementation. Of the 219 PBSPs reviewed, only 183 (84%) had been implemented by the end of the current site visit. For those PBSPs that had not been implemented, the final date of the site visit (10/12/2012) was substituted by the Monitoring Team for the implementation date in order to calculate timeliness. Therefore, the information presented below reflects the minimum possible delay experienced in implementing the PBSPs submitted since 5/1/2012.<br>• An average of 15 days was required to obtain approval from the peer review committee. The number of days required for peer review approval ranged from zero days to 77 days.<br>• An average of 12 days was required to obtain approval from the Human Rights Committee. The number of days required for Human Rights Committee approval ranged from zero days to 121 days.<br>• An average of 43 days was documented between first submission to the peer review committee and the implementation of the PBSP. The number of days documented between first submission to the peer review committee and implementation of the PBSP ranged from zero days to 163 days.<br><br>As indicated above, only 183 of 219 PBSPs (84%) had been approved and implemented. Although it was anticipated that the PBSPs not implemented would be those submitted for review just prior to the site visit, the data did not reflect this to be the case. Rather, the data reflected that, by the end of the site visit, the average number of days since submission of the PBSPs for review was 67 days. As the Facility had documented when PBSPs had been denied approval or otherwise withdrawn, the Monitoring Team made presumption was that these PBSPs lacking implementation remained in the review process.<br><br>Based upon the information presented above, it was evident that DSSLC was unable to provide timely behavior intervention for many individuals determined to be in need of a PBSP.<br><br><u>PBSP Review</u><br><u>Historical Perspective</u><br>During the September 2010 site visit, numerous weaknesses were noted in both behavior assessment and intervention. These weaknesses included that 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 | |

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| | | PBSPs to review during a site visit that reflected the current iteration of the PBSP. This was again true at the time of the April 2012 site visit, which limited the review at that time to only five PBSPs. Based upon observations and a review of those five PBSPs, it did appear that improvement had been achieved in many areas. Due to the small sample, however, there was not yet sufficient evidence to support a determination of substantial compliance with the Settlement Agreement.<br><br><u>Current Site Visit</u><br>At the time of the current site visit, a sample of 18 records was selected for review using the process previously described. The table below reflects a review of those 18 records. | |

| PBSP Element | Baseline | 4/2011 | 10/2012 |
|---|---|---|---|
| Rationale for selection of the proposed intervention. | 50% | 100% | 89% |
| History of prior intervention strategies and outcomes. | 50% | 100% | 100% |
| Consideration of medical, psychiatric and healthcare issues. | 40% | 100% | 94% |
| Operational definitions of target behaviors. | 70% | 100% | 89% |
| Operational definitions of replacement behaviors. | 70% | 100% | 83% |
| Description of potential function(s) of behavior. | 30% | 100% | 83% |
| Use of positive reinforcement sufficient for strengthening desired behavior | 10% | 0% | 83% |
| Strategies addressing setting event and motivating operation issues. | 60% | 100% | 83% |
| Strategies addressing antecedent issues. | 60% | 100% | 83% |
| Strategies that include the teaching of desired replacement behaviors. | 10% | 100% | 72% |
| Strategies to weaken undesired behavior. | 30% | 100% | 100% |
| Description of data collection procedures. | 20% | 100% | 67% |
| Baseline or comparison data. | 0% | 80% | 100% |
| Treatment expectations and timeframes written in objective, observable, and measureable terms. | 0% | 100% | 94% |
| Clear, simple, precise interventions for responding to the behavior when it occurs. | 30% | 100% | 100% |
| Plan, or considerations, to reduce intensity of intervention, if applicable. | 0% | 100% | 100% |

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| Signature of individual responsible for developing the PBSP. | 90% | 100% | 100% |

Based upon the information obtained from the current review, it was evident that DSSLC had managed to maintain the majority of improvements reflected in the five PBSPs from the April 2012 site visit. Although ratings were somewhat lower, this was not unexpected for a larger, more representative sample. Overall, the PBSPs reviewed during the current site visit reflected sound behavior analytic practices, were based upon adequate functional assessments, and were likely to achieve success in changing undesired behavior.

In only two areas were substantial limitations revealed in the PBSPs.

Strategies for Teaching Replacement Behaviors. In a small number of PBSPs, the methodology did not reflect procedures likely to increase or strengthen replacement behaviors. In most circumstances, this was due to inadequate functional assessments. As noted in Provision K.5, 26% of functional assessments failed to identify functionally equivalent replacement behaviors. As a result, the PBSPs that were based upon those functional assessments lacked clearly identified replacement behaviors and often did not include the necessary teaching strategies. For example, the PBSP for Individual #127 presented a replacement target of selecting an appropriate anger management strategy. This target, although it may have represented a desirable skill, was not indicated to serve the same function as physical aggression and unauthorized departure, the two behaviors targeted for reduction. As a result, efforts to increase the selection of appropriate anger management strategies was not likely to reduce or replace physical aggression or unauthorized departure.

Description of Data Collection Procedures. The limitations noted in relation to data collection involved a lack of specificity in relation to data collection. Six PBSPs did not include specific instructions about how to collect data. In these PBSPs, instructions consisted only of general statements about how to record the behavior or what form to use to collect data.

Based upon the review of 18 recent PBSPs, it did appear that improvement had been maintained in many areas. This reflected substantial progress for DSSLC. At the same time, however, documentation reflected a substantial delay often existed between submission of a PBSP for review and actual implementation of the PBSP. DSSLC must remain aware of the fact that even very sophisticated behavior interventions are of limited benefit if delays allow undesired and potentially dangerous behaviors to continue. Every effort must be made to ensure that PBSPs are implemented in a timely manner.

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<tr><td>K10</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.</td><td>Historical Perspective<br>During the April 2012 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.<br><br>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.<br><br>Current Site Visit<br>At the time of the current site visit, a sample of 18 records was selected for review using the process previously described. The table below reflects a review of those 18 records.<br><br>
<table>
<tr><th>Graph Element</th><th>Baseline</th><th>4/2012</th><th>4/2012</th></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Horizontal axis and label</td><td>100%</td><td>80%</td><td>100%</td></tr>
<tr><td>Vertical axis and label</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Condition change lines</td><td>0%</td><td>80%</td><td>67%</td></tr>
<tr><td>Condition labels</td><td>0%</td><td>80%</td><td>67%</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>80%</td><td>67%</td></tr>
</table>
<br>Based upon the review of the PBSPs and data graphs, it did appear that improvement had been achieved and maintained in many areas. The data graphs and progress notes did reflect that not all graphs included condition change lines, condition labels, and demarcations of environmental changes.<br><br>Although DSSLC reported that improvements were introduced in collecting and reporting interobserver agreement, these changes were not evident in the documentation submitted by the Facility. For some individuals, problems encountered in staff completion of data collection were mentioned in the narrative of progress notes. On several progress notes, the percentage of data forms completed by staff was reported. It</td><td>Noncompliance</td></tr>
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| | | was not indicated, however, whether the documented percentage reflected the number of data forms completed correctly or just the number of forms staff had submitted. In none of sampled records, however, was IOA reported or used in the assessment of treatment response.<br><br>Although DSSLC had 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. Furthermore, the lack of IOA information in the data graphs substantially limited the utility of the data. | |
| 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.<br><br>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. The Facility offered statements that efforts were underway to assess the integrity of PBSP implementation. No data were made available, however, to reflect PBSP integrity measures. Therefore, readability statistics were the only data available to assess Provision K.11.<br><br>Although no definitive data were available, observations conducted during the site visit reflected that staff were not able to effectively provide behavior interventions.<br>• In residence 523C, one individual was observed inserting his fingers in his ears in response to loud noises and verbalizations by peers. Rather than modify the environment by reducing noise or moving the individual away from peers, as was expected, staff prompted the individual to put his hands down. The individual cooperated with these prompts. As time progressed, however, prolonging the exposure to sound levels, the individual became increasingly agitated. Within five minutes, the individual began to exhibit bursts of pounding the dining table with his fists and slapping himself on the face. Staff made no further effort to intervene.<br>• In residence 522D, an individual was supposed to be monitored closely due to incidence of rumination, with the requirement that staff interrupt displays of rumination. Observation reflected that staff did not monitor the individual.<br><br>Based upon the lack of data regarding PBSP integrity, as well as observations of failures | Noncompliance |

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| | | to implement intervention strategies, there was no indication that DSSLC had acted to ensure that PBSPs were routinely and accurately implemented by staff. | |
| 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. In the document request, the Facility provided evidence of two training sessions for Behavior Services staff. This training involved instruction on behavior assessment on July 30 2012 and cases presentations on August 21 2012. No other documentation of competency-based training for Behavior Services staff or other staff was made available.<br><br>During the site visit, however, the Monitor was informed of competency-based training being conducted with DCP staff by the Behavior Analysis Research Clinic (BARC) staff from the University of North Texas. The training program had three primary elements, 1) instruction on three informal behavior intervention procedures, 2) instruction on procedures for data collection, and 3) training on specific PBSPs.<br><br>For the first element of the training, DCP staff were required to participate in three vignettes and demonstrate how to address the behaviors modeled by the BARC trainers in those vignettes. The DCP staff were then presented live and video-based training on skills appropriate for each vignette. The DCP staff were then presented on the following day with the same vignettes and were scored on their responses.<br><br>For the second element of the training, staff were provided with live and video-based training on data collection procedures, such as interval and frequency data collection. They were then presented with videotaped scenarios in which BARC staff modeled behaviors. The DCP staff were then tasked with collecting data and answering questions related to data collection.<br><br>In the third element of the training, staff were provided with instruction regarding PBSPs for which they would be responsible as part of their routine job assignments. This instruction involved both live training and "homework". The DCP staff were then required to demonstrate competence for each PBSP.<br><br>Training data provided by BARC reflected that DCP staff consistently improved skills related to all three elements of the training. In addition, interviews and observations with six DCP staff involved in the training that occurred during the site visit reflected not only improved skills, but also greater confidence and enthusiasm for their jobs.<br><br>The training conducted by the BARC staff had involved only a limited number of staff over the past three months. As the training was successful at increasing skills and reflected evidence-based practices, DSSLC is strongly encouraged to expand this training | Noncompliance |

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| | | to include more staff. | |
| 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 nine staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 55 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 1:26 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. Data graphs should include specific information about the reliability of treatment data. (Provision K4)
3. The participation of DSP staff in the review of treatment data, as well as documentation of that participation, must be consistently conducted. (Provision K4)
4. 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)
5. The Facility should take steps to ensure that PBSPs are implemented in a timely manner.
6. 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 | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSL Self-Assessment 9/24/12<br>2. DSSLC Action Plan 9/24/12<br>3. Denton Presentation Book for Section L<br>4. DADS Policy 009.1 Medical Care 9/6/12<br>5. DSSLC policy procedure for seizure management. Undated, and no policy number<br>6. DSSLC Guideline on Modified Barium Swallow Study, 4/19/12<br>7. DSSLC Clinical Death Review Policies and Procedure Manual, Committees and Councils – 07A, Date: May 15, 2006<br>8. DSSLC Administrative Death Review Committee, Policies and Procedure Manual, Committees and Councils – 07B, Date: May 1, 2006<br>9. DSSLC Clinical and Administrative Death Review Tracking Log for Individuals #97, #536, and #496<br>10. DSSLC Clinical and Administrative Death Review Recommendation Tracking Logs for Individuals #97, #536, and #496<br>11. DSSLC Unusual Incident Investigation Reports for Deaths for Individuals #97, #536, and #496<br>12. Texas Department of State Health Services – Vital Statistics Unit, Death Certificates for Individuals #97, #536, and #496<br>13. DSSLC Final Comprehensive Nursing Assessment for Individuals #97, #536, and #496<br>14. For the past six months, Physical Nutritional Management Committee Meeting Minutes (PNMC), and all related medical quality assurance data, graphs, and analysis<br>15. List of current physicians, CPR certificates, and CME training completed in the past six months<br>16. List of all Individuals who were treated for osteoporosis, and medication prescribed for treatment of osteoporosis<br>17. All DEXA reports from the previous six months<br>18. Annual physician summary, ISP, Chronic problem progress record, and last 12 months of laboratory data, consultation reports, and imaging studies for individuals #596, #416, #581, #704, #520, #409, #18, #488, #622, and #89<br>19. List of all individuals over the age of 50, along with screening colonoscopy results, and clinical rationale why a screening colonoscopy was not provided, if the study was not completed<br>20. The two most recent integrated progress notes (IPNs) written by each physicians<br>21. List of all females over 40 years old, and the dates of their past two screening mammogram studies<br>22. Most recent annual physician summary, past 12 months of laboratory results, and most recent ISP for all individuals with Phenylketonuria (PKU)<br>23. List of the incidence of decubitus ulcers, bowel obstruction, pneumonia, and urinary tract infections that occurred during the past six months<br>24. Annual physician assessment, ISP and addendum to the ISP, all medical consultations and imaging reports specific to degenerative spine disease for individuals #307, #47, #697, #191, and #417<br>25. Annual physician summary, ISP and addendums to the ISP for past 12 months, accucheck log for past month, last two chronic problems record, endocrinology reports for the management of diabetes, and laboratory data for past 12 months, for individuals #335, #331, #401, #89, and #753 |

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| | 26. Active clinical records for Individuals #335, #331, #401, #89, #753, #596, #416, #581, #704, #520, #409, #18, #488, #622, #89, #307, #47, #697, #191, #417, #705, #505, and #734<br>27. Most recent annual physician summary, last two chronic problems records, most recent ISP, and last three years consultation reports specific to medical consultations for malignancy for Individuals #131, #605, #104, #20, and #492<br>28. List of all individuals treated for seizure disorder, and list of their diagnosis, and medications used to treat seizure disorder<br>29. List of all consultations for seizure disorder during the past six months<br>30. List of all individuals who were hospitalized for seizures during the past six months<br>31. List of all individuals who had status epilepticus during the past six months<br>32. List of all individuals who had a diagnosis of refractory seizure disorder<br>33. List of individuals who were scheduled for VNS evaluation, or placement<br>34. List of AEDs used at the Facility, and percentage of AEDs that are considered older AEDs (Phenobarbital, Dilantin, and Mysoline)<br>35. List of individuals who were prescribed two, three, four, and five AEDs, respectively<br>36. Community Living Discharge Plan (CLDP) record, and post move monitoring data for Individual #505<br>37. All data, reports and summaries for medical providers audits conducted during the last six months<br>**People Interviewed:**<br>1. Steven Kubala MD, Medical Director<br>2. Delia Schilder, RN, Chief Nurse Executive (CNE)<br>3. Sherri Courtney, RN, Nursing Operations Officer (NOO)<br>4. Laura Stoffels, RN, Nurse Investigator<br>5. Valerie Kipfer, RN, State Office Nursing Coordinator<br>**Meeting Attended/Observations:**<br>1. Annual Individual Support Plan Meeting (ISP), Individual #750<br>2. Observation of Individuals at their living areas: Cedar Falls A, B, C and D; Houston Park 513 and 514; Garden Ridge C and 515; Westridge 519 and 520 |
| | **Facility Self-Assessment:**<br>Provision L.1: The Facility reported noncompliance with Provision L.1, and the Monitoring Team concurs with this determination. The Monitoring Team believes that the Self-Assessment did not adequately assess many issues that require improvement. For example, the Facility did not assess physicians' participation in the IDT process, or their involvement in the CLDP process; and did not assess physicians' practice with regards to management of acute and chronic care conditions. Upon review of the Facility's action plan, the Monitoring Team agrees that the action steps identified will help lead the Facility to compliance.<br><br>Provision L.2: The Facility determined that it was noncompliant with Provision L.2, of the Settlement Agreement, and the Monitoring Team agrees with this determination. The self-assessment did not specifically address compliance issues; for example, the self-assessment stated "Review revealed the physician performing medical audits is certified and has extensive experience providing medical quality reviews", and "Review revealed the physician providing additional audits has many years of experience in pulmonology and general medicine". Although these are excellent qualities to have, the statements are |

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| | irrelevant to the self-assessment process. Importantly, the assessment and action plan did not address issues related to the new medical management component of the medical provider audit process. The action steps listed on the action plan for Provision L.2, will help lead to compliance; however, addition specific actions are needed, such as enhancing the medical management component of the medical provider audit process, and developing a mechanism to track and trend mortality review data, and ensure improvement initiatives for the mortality review process are effective.<br><br>Provision L.3: The Facility self-reported substantial compliance with Provision L.3, of the Settlement Agreement, and the Monitoring Team disagrees with this assessment, and determined noncompliance. The self-assessment and action planed focused mostly on the internal medical audit review process, and to some extent on its recent development of some clinical indicators. The provision requires the Facility to develop and implement a mechanism to address system issues related to medical quality assurance, and the Monitoring Team did not identify evidence that indicates such a process is in place. For example, there is no policy and procedure for a medical quality assurance process that reflects the Facility's current practice; the Facility did not regularly perform trends analysis for, or report on, all relevant clinical indicators that should be reported on.<br><br>Provision L.4: The Facility reported that it was not in compliance with Provision L.4, of the Settlement Agreement. The Monitoring Team agrees with the listed action steps for this Provision; however, more detail should be included. For example, action step 1 states that the Facility will develop additional clinical pathways, and should list what clinical pathways will be developed. Action step 2 indicates that "other processes established will provide basis for modifying treatments"; other processes should we listed; action step 3 states that the Facility will develop and implement medical care policies consistent with integration of clinical services; however, additional policies and procedures are required for all initiatives, and practices within the medical department. For example, the Facility must develop a policy and/or procedure to address its medical quality assurance process, and mortality review process. |
| | **Summary of Monitor's Assessment:**<br>The Monitoring Team noted continued, and significant, improvement in the provision of direct medical care and medical administration. In general, annual physician assessments were more comprehensive, included all known medical conditions, and included a more comprehensive action plan for each known medical condition. The current medical problem list was more complete, compared to previous reviews. Medical assessments were completed timely. Physicians have begun the process of evaluating chronic medical conditions on a quarterly basis. There has been appreciable reduction in the number of cases of pneumonia and hospitalizations, and there have been no unusual adverse outcomes identified with recent deaths. The medical director continued to develop and implement meaningful improvement strategies, such as including an external physician who is certified in medical quality assurance to participate in the internal medical provider audit process, and contracting with a pulmonologist to provide educational training to staff and to provide direct patient care.<br><br>Continued, and more assertive, improvements are necessary to achieve compliance. Of primary concern following this review was the fact that physicians, in general, were not assertively participating in the IDT |

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| | and CLDP processes, and the outcomes from not fully and meaningfully participating in these two processes was noted during this review. Follow-up to full resolution of acute medical conditions remained an outstanding issue. The Facility did not provide or enable regular continuing medical education (CME) events on serious conditions that commonly occur in individuals with developmental disabilities, and in general the Facility did not provide efficacious management of such conditions. Furthermore, the Facility must develop a mechanism to ensure efficient and efficacious management of clinical database elements. The following are additional comments specific to each Provision:<br><br>Provision L.1: Based on review of clinical documents, and observations of Individuals who reside at the Facility, the Monitoring Team determined that the Facility remained not in compliance with Provision L1. Multiple findings, in areas of acute and chronic care management, preventive health measures, participation with the IDT process, and failure to adequately participate in the community living discharge plan process (CLDP), and monitoring of clinical indicators of those transferred to the community, all demonstrated the need for improvement. Compliance will require that the Facility comprehensively and immediately address acute care issues, with regular follow-up of individuals through resolution; provide effective management and regular assessments of chronic care conditions, especially for those conditions that are commonly associated with individuals with developmental disabilities; fully participate in the IDT process and ensure that all health care issues are well communicated to the team; and ensure that all clinical supports and services are identified and in place during CLDP meetings, and closely monitored following transfer to the community.<br><br>Provision L.2: The Monitoring Team determined that the Facility was not in compliance with Provision L.2, but did observe some important improvements, for example, the Facility continued to enhance the medical provider audit process by ensuring that an external physician who was certified in medical QA performed their internal audits. Meaningful action plans were developed for medical provider audits that were assessed to be deficient, and quality assurance initiatives were developed to ensure that action plans were completed; however, the action plans were not addressed timely by the provider. The Monitoring Team determined that the medical management component of the medical provider audit process was ineffective in assessing the provider's clinical performance abilities. Compliance will require that the Facility review the medical management audits, and ensure that they identify specific treatment outcome data that reflects the provider's clinical performance. The Monitoring Team also expects that all providers will be assessed for clinical performance during the medical provider audit process, and that providers will be assessed for several medical management performance outcomes, during each review process.<br><br>The mortality review process continued to significantly improve by the addition of an external physician who regularly attended all mortality reviews, and by ensuring a more robust review of deaths. Compliance will require enhanced physician and nursing staff participating in the mortality review process by probing for a more detailed root cause analysis of each death. Also, the Facility must develop a mechanism to effectively track and trend mortality review data, and ensure full implementation of meaningful recommendations.<br><br>Provision L3: Following review of medical quality assurance data, and associated graphs, analysis, and |

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| | PNMC meeting minutes, and because there was no associated policy for the Facility's medical quality assurance process, the Monitoring Team determined that the Facility in not in compliance with Provision L.3.<br><br>The Facility provided a table of clinical indicators, with the reviewing authority and frequency of review of each. Items from the table of clinical indicators might be reviewed monthly, quarterly, annually, or upon request. This table provided an easy reference that could be used to identify who would have information and to guide auditing for documentation of review. One table, for apartment 512C, showed the ability of the Facility to break down the information in a way that will provide essential information in planning improvements. However, the Facility did not provide information on monitoring to ensure reviews took place, other than the reports provided to the QA/QI Committee.<br><br>The Facility also provided sets of data on infections, decubitus ulcers, and pneumonia; these data were not accompanied by any documentation of review, assessment, and actions. Furthermore, the Facility reported a successful example of an improvement action taken as a result of review of clinical indicators. Data showed an increase in urinary tract infections. The Facility reviewed the data and implemented actions including retraining and monitoring on proper cleaning and washing of women who have a toileting accident and on handwashing, as well as ensuring adequate fluid intake.<br><br>Although the table of indicators, the data provided, and the example of action demonstrated the Facility had taken a major step toward using such clinical indicators of efficacy to lead toward improved services, it was not clear that these indicators were regularly used as part of an organized and routine process of medical quality assurance that initiates outcome-related inquiries, initiates corrective actions, and monitors to ensure remedies are achieved. Compliance will require that the Facility develop a comprehensive medical quality assurance process, that reviews regularly data of common and serious medical conditions, assesses the data to determine issues that need to be addressed, and is used to enhance clinical practice and outcomes at a system level.<br><br>Provision L4: Because the Facility did not follow the DADS policy and procedure on Medical Care, and the Facility did not provide policies, procedures, and, or guidelines for medical operations including medical quality assurance processes (and the Medical Director reported policy is in process of being drafted to match the DADS policy and is not yet available). the Monitoring Team determined that the Facility is not in compliance with Provision L.4. Compliance will require the development and implementation of policies, procedures, and, or guidelines that will reflect the Facility's practices with regards to medical services, and medical quality assurance processes. The Monitoring Team strongly recommends that meaningful and effective clinical pathways be developed for the more serious medical conditions that occur in individuals with developmental disabilities. The Policy and procedure for seizure management should be updated to reflect current practice standards. The DADS policy on medical care should update its policy to reflect CDC recommendations regarding immunization practices. |

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| L1 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. | Provision L1 requires a comprehensive review of all services related to the provision of medical care at the Facility. The Monitoring Team selected common and important clinical issues to review when assessing the Facility's ability to provide medical treatments to the individuals who reside at the Facility. During this review period, the Monitoring Team assessed the following areas: Medical administration; management of acute and chronic medical care; preventive health care; physician participation at ISP meetings and CLDP meetings; and post move monitoring of health care issues.<br><br><u>Medical Administration</u><br>To assess adequacy of the medical department, the Monitoring Team reviewed the number of current practicing physicians, nurse practitioners, and support staff for the medical office; and reviewed physicians licensure, continuing medical education (CME), and CPR training status. The Monitoring Team also assessed the Facility's ability to manage clinical date elements.<br><br>The Facility had six practicing physicians, one nurse practitioner, and one full-time medical director, four clerks, four clinic nurses, a scheduling clerk, and an administrative assistant to support the medical director. Upon review of the requested list of practitioners and their caseload, the Monitoring Team noted that the list stated that 68 individuals from Timberhill were being provided service by a physician assistant (but stated "None" in the column for name); the list did not indicate who was covering that caseload. Therefore, the Monitoring Team was unable to determine the overall average caseload for practitioners; however, it was estimated that the average caseload was well bellow 70 individuals per practitioner.<br><br>All practitioners were current with CPR training, and demonstrated CME training as required for licensure. Review of the Texas Medical Board Website indicated that the medical licenses of all practicing physicians were current. The Monitoring Team did not identify CME training venues specific to areas of developmental disabilities. There were no on-site or off-site CME events offered to physicians specific to issues related to developmental disabilities.<br><br>The Monitoring Team determined that the Facility maintains a robust medical department. It is highly recommended that regular CME events be offered to all medical practitioners on issues relevant to individuals with developmental disabilities, such as management strategies for cerebral palsy, and degenerative spine disease, and the management of spasticity. Per report of the medical director and documents provided to the Monitoring Team, the Facility provided one in-service training for physicians specific to aspiration pneumonia in persons with developmental disabilities. This was a positive finding; the Facility should continue to identify areas in which such specific training would be useful and identify opportunities for such training to provide CME credits. | Noncompliance |

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| | | During the on-site review at the Facility, the Monitoring Team requested data elements, specific to various diagnoses, for example, a list of all individuals with a diagnosis of degenerative spine disease, osteoarthritis, spasticity and cerebral palsy, was noted to be inaccurate by not identifying all individuals with such conditions. Because the Facility was unable to provide timely and accurate clinical data, the Monitoring Team strongly recommends that the Facility enhance mechanisms to improve on its ability to accurately and timely manage data related to medical issues.<br><br>Acute Care<br>To assess the Facility's ability to address acute care issues, the Monitoring Team requested that the Facility provide the incidence of pneumonia, decubitus ulcers, urinary tract infections and bowel obstructions.<br><br>Pneumonia: The incidence of pneumonia was not provided in the response to the document request.<br><br>Decubitus Ulcers: The document request provided for review included decubitus ulcers from October 2011, through August 2012; in order to provide the documents for review prior to the compliance visit, the Facility was able to provide four months of data for this reporting period, and eleven months of data was provided in total. Of the data provided, the Facility identified a total of 21 decubitus ulcers from April through August 2012, and 14 decubitus ulcers during the preceding four-month period. Importantly, the incidence of stage three and four lesions increased from five to nine, during the same period.<br><br>Bowel Obstruction: The Facility reported one incident of bowel obstruction for the past 12 months.<br><br>Urinary Tract Infections: Data for urinary tract infections was not provided in response to this document request.<br><br>Because data was not provided as requested, the Monitoring Team could not definitely determine efficacy of clinical practice, specific to pneumonia, decubitus ulcers, and urinary tract infections.<br><br>Preventive Health<br>To assess the Facility's ability to provide preventive health care, the Monitoring Team reviewed clinical records, and data specific to screening colonoscopy, screening mammogram, and routine monitoring of secondary conditions related to Down Syndrome. | |

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| | | Screening Colonoscopy: The Monitoring Team requested a list of all individuals over the age of 50, with the date of their last colonoscopy, and the reason for the colonoscopy, and was to include the rationale for not providing a screening colonoscopy for those who did not have the procedure. The Monitoring Team was provided with a print out of the schedule for all persons over 50 who were scheduled to have a colonoscopy, and it did not include a list of those who were over 50 and did not have the procedure, and reason why they did not have the procedure. For this reason the Monitoring Team could not assess compliance.<br><br>Screening Mammogram: From a list of all women over the age of 40, a total of 163 individuals required screening mammograms. Of the 163 women, only 54 (33%) were current with their screening mammogram, and 109 (67%) were not current.<br><br>The Monitoring Team strongly encourages the Facility to enhance timeliness with obtaining preventive health diagnostics, when screening is not contraindicated. For those individuals who have potential contraindications to screening, the clinical rationale must be clearly documented in the ISP.<br><br>Down Syndrome<br>Down Syndrome is a condition that may manifest many medical conditions, such as degenerative spine, congenital stenosis of the spine, subluxation of the spine, arthritis, and subluxation of joints, hematological conditions, cardiac anomalies, and dementia. The Facility must routinely assess individuals with Down Syndrome for common comorbid conditions.<br><br>To assess the Facility's ability to manage chronic health care issues, and preventive health care of individuals with Down Syndrome, the Monitoring Team was provided a random sample of ten individuals with the diagnosis of Down Syndrome, and reviewed their annual physician summary, quarterly medical review, medical consultations, EKG reports, annual Individual Support plans (ISPs), 12 months of laboratory data, and imaging reports. The Facility chose this sample by an electronic random selection conducted by the Facility's information technology department's database.<br><br>Of the ten samples, nine out of ten (90%) regularly assessed thyroid hormone levels; one out of ten (10%) of the annual physician assessments delineated a specific comment regarding clinical manifestations of Down Syndrome; zero out of ten (0%) of the annual physical assessments and quarterly medical reviews provided a comprehensive assessment for common conditions known to occur in individuals with Down Syndrome; zero out of ten (0%) of the annual ISPs documented necessary supports and services required for individuals with Down Syndrome; four out of ten samples (40%) documented a plan to address abnormal blood test values (high MCV); two out of ten | |

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| | | (20%) indicated routine and appropriate assessments of orthopedic conditions associated with Down Syndrome.<br><br>The Following highlights examples of concern, specific to the medical management of individuals with Down Syndrome:<br><br>Individual #596<br>The Monitoring Team request copies of the past 12 months of laboratory studies, and a TSH (thyroid study) was not provided, nor was hypothyroid screening discussed within the context of the annual or quarterly medical assessments. The Individual was noted to have seen an orthopedic surgeon for assessment of the Individual's known significant degenerative spine disease, and cervical compression fracture, and although surgery was not recommended by the surgeon, the primary care physician did not specifically address safety issues, or inform the IDT of the potential of worsening disability, such as total paralysis, or even death, secondary to further trauma of the spine. There was no recent orthopedic follow-up to address the Individual's degenerative changes of the knees and diagnosis of anterior cruciate ligament tear of the knee. The annual ISP dated 4/24/12, did not indicate degenerative spine disease as a serious risk. There was no comprehensive plan noted in the annual physicians summary, or quarterly medical reviews, addressing osteoarthritis of the hands, and there was no comprehensive plan to address the Individual's osteoarthritis of the knees, and torn ligaments. The individual was known to have macrocytosis, which was not documented on the annual physician summary or quarterly medical reviews. The ISP did not delineate Down Syndrome as a medical condition that requires annual assessment, and the annual physician assessment and quarterly medical reviews did not indicate a formal plan for Down Syndrome. Importantly, the risk assessment, dated 4/24/12, did not list the individual's degenerative spine disease with myelopathy, as a condition that can lead to worsening disability, death, and hasten fall related injuries. , and there was no specific service objective noted to address this critical issue, even though the individual sustained five known falls in the past year. The ISP also indicated the Individual to have a low risk for fractures, despite having five falls in the past year, known degenerative spine disease with myelopathy, and degenerative changes of the knees and known ligament tear of the knee;,all of these conditions can precipitate the individual to falls, and fall related injuries.<br><br>The Monitoring Team has serious concern over the lack of comprehensive plans and integration of services to address the support needs for several important medical conditions, especially degenerative spine disease, compression fracture with myelopathy, osteoarthritis of the hands, and knees, and anterior cruciate ligament tear of the knee. The Monitoring Team was also concerned osteoarthritis and ligament tear were not routinely assessed by orthopedic specialists, and there were no formal plans, other then | |

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| | | pain management, to address risks associated with these conditions.<br><br>Individual #416<br>The Monitoring Team noted that a TSH was obtained and was normal. The Individual cervical spine x-ray, dated 1999 demonstrated degenerative changes of the cervical spine. Subsequent x-rays in 2001 and 2003, noted that the x-ray study was unsatisfactory; hence, could not delineate if pathology had worsened. The issue of degenerative spine disease was not further explored by the physician, nor reflected as a diagnosis, or commented on in the ISP. The Individual was noted to have spasticity; however, this condition was not reflected by a medical plan, service objective, or documented as an issue in the ISP. The physician did not document a completed examination of deep tendon reflexes or pathological reflexes. There was no comment in the annual physician review, quarterly medical review, or ISP of the diagnosis of Down Syndrome, and potential manifestations that may develop as a result of Down Syndrome. The Individual had laboratory confirmation of macrocytosis, with a low red blood cell count, and this was not reflected as a diagnosis, nor was there evidence to support that this condition was assessed.<br><br>The Monitoring Team is concerned that there was no documented medical plan to address degenerative spine disease, macrocytosis, and spasticity, and that the there was no documented plan to address Down Syndrome, as a specific medical issue.<br><br>Individual #581<br>A TSH was obtained and noted to be normal. A blood count indicated macrocytosis with low red blood cell count, and there was no evidence documented the etiology of these findings, nor was macrocytosis listed as a diagnosis or problem. The Individual was noted to have a history of a cardiac defect from childhood, and despite known edema of the lower legs, the Individual has not had a repeat echocardiogram since 2010, and had not been referred to a cardiologist since 2003; an EKG was done in 2010. The most recent annual physician summary, dated 5/3/12, indicated that echocardiogram would be obtained, but there was no documentation to indicate that such a study had been completed. There was no evidence to indicate the cervical spine disease had been assessed by imaging studies since cervical spine X-rays in 2007. There was no documentation to indicate that Down Syndrome was assessed as a medical entity. The ISP did not include risk factors that arise from Down Syndrome, nor the Individual's cardiac condition, as risk factors. Importantly, the ISP did not delineate necessary supports and services for known medical conditions.<br><br>Based on review of the documents provided, the Monitoring Team is concerned that important manifestations of Down Syndrome, including cardiac anomalies, potential cervical spine conditions, and hematologic issues were not comprehensively addressed | |

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| | | by the physician and the team<br><br>Individual #704<br>A TSH was obtained, and within normal limits. X-rays of the spine demonstrated degenerative spine disease, and degenerative disc disease. Neither of these issues were listed as a diagnosis, nor was a medical plan developed. The Individual was noted to have macrocytosis and low red blood cell count, which was not listed on the annual physician summary or quarterly medical reviews, and there was no indication that this condition was evaluated. The Individual was noted to have trace tricuspid valve disease, which was not routinely assessed, nor listed on the diagnosis. The annual physician summary, and the ISP did not adequately reflect Down Syndrome, and its manifestations, as a specific medical condition that required regular assessment. Importantly, the ISP did not adequately reflect the supports and services necessary for the Individual's known medical condition. Of significant concern is that the Individual was known to have atlanto axial subluxation in the past, and there was no diagnosis, or medical plan to address this condition, even though there is no evidence that specific imaging studies were obtained to exclude this diagnosis.<br><br>Individual #409<br>Serious concerns noted by the Monitoring Team included a known and documented diagnosis of degenerative spine disease, which had not been routinely assessed, despite known central canal stenosis, history of severe falls, and a long standing history of degenerative spine disease. Documents revealed that the individual had become non-ambulatory, but did not delineate the clinical etiology of the Individual's inability to ambulate. Although some health care actions were delineated in related assessments, the ISP did not adequately and comprehensively address the actions needed to respond to the Individual's health care issues.<br><br>Individual #622<br>Cervical spine x-ray dated 10/2/06 indicated degenerative disk disease in the lower cervical spine; however, this condition was not listed as a diagnosis, nor were regular assessments conducted for condition. It should be noted that for conditions identified by the physician, the medical plan documented on the annual physical assessment was excellent, and should serve as a model example for completing a medical plan.<br><br>Conclusion:<br>The Monitoring Team determined that the Facility did not adequately and routinely assess individuals for manifestations of Down Syndrome, such as potential serious orthopedic, hematological, cardiac conditions, and that there was inadequate documentation of such conditions in the individuals' ISPs. | |

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| | | Chronic Health Care Conditions<br>To assess the Facility's ability to provide comprehensive care for chronic health care issues, the Monitoring Team reviewed clinical data, and records specific to osteoporosis, seizure disorder, diabetes, malignancy, phenylketonuria, and degenerative spine disease.<br><br>Osteoporosis: From a list of individuals being treated for osteoporosis, the Monitoring Team evaluated the treatment of osteoporosis by reviewing the medication list and active clinical record of the first 20 individuals on the list.<br><br>Of the 20 samples, three out of 20 (15%) were prescribe a bisphosphonate for the treatment of osteoporosis; 17 out of 20 (85%) were prescribed nasal Calcitonin; 17 were prescribed vitamin D and Calcium supplementation (85%); 20 out of 20 had a screening bone density study that was obtained within the past three years (100%), zero out of 20 (0%) had documentation in the active clinical record demonstrating that a comprehensive evaluation to determine the etiology of low bone density; and zero out of the 17 individuals ((0%) who were prescribed long-term nasal calcitonin had the documented clinical rationale for long-term use of nasal calcium, documentation of its efficacy, ability of the individual to participate with the administration of the drug, and periodic evaluation of the individual's nasal mucosa and septum for potential side effects.<br><br>The Monitoring Team compliments the Facility for its robust screening for low bone density, and providing vitamin D and calcium supplementation when clinically appropriate. The Monitoring Team recommends that the Facility provide in the active clinical record the clinical rationale for long-term administration of this drug. The medical literature is ambiguous regarding the efficacy of long-term nasal Calcitonin. The Monitoring Team did not identify periodic assessments of the nasal mucosa and septum, which should be routinely assessed to ensure no side effects from the chronic use of nasal Calcitonin; and individuals should be routinely assessed to ensure that they are able to adequately assist with the nasal administration of the drug. The Monitoring Team believes that the use of Nasal Calcitonin should be carefully monitored for efficacy, and side effects, and the rationale for its use be well documented. Most important, the Monitoring Team did not identify a comprehensive evaluation of the etiology for low bone density, and before any treatment is administered, a search for potential reversible causes of low bone density should be sought.<br><br>Degenerative Spine Disease: Degenerative spine disease is a serious medical condition that commonly occurs in people with developmental disabilities. The condition can result in severe pain, and behavior exacerbation, as well as progress to paralysis and death. The Monitoring Team chose the first five individuals from a list of those reported to have a diagnosis of degenerative spine disease and reviewed the most recent annual physical summary, most recent two quarterly assessments, all relevant consultations for | |

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| | | the past three years, and the most recent ISP, and past six months addendum to the ISP.<br><br>Of the five cases reviewed, one out of five (20%) demonstrated an annual physical assessment that clearly delineated a comprehensive and meaningful plan to address degenerative spine disease; one out of five (20%) included appropriate use of medical consultants to assist in the management of degenerative spine disease; one out of five (20%) included appropriate imaging follow-up to help monitor progression of the condition; and one out of five (20%) included an ISP that clearly delineated the condition. The following are examples of the Monitoring Teams concern regarding the management of degenerative spine disease:<br><br>Individual #307<br>The Individual was known to have degenerative spine disease. The most recent imaging study of the spine was a CT of the cervical spine in 2005, which demonstrated multilevel degenerative spine disease. Record review for the past three years indicated that the Individual had not been referred to a medical specialist to assess or monitor this condition. There was no evidence to indicate that degenerative spine disease was routinely assessed by specific examinations and assessments, such as the timed get up and go test. The most recent annual ISP did not delineate a service objective specific for the management or monitoring of progressive spine disease. Importantly, an addendum ISP dated 9/25/12 indicated that the Individual was sustaining more frequent falls, and the etiology was unknown. The physician did not participate at the ISP meeting.<br><br>The Monitoring Team has concerns that the management of degenerative spine disease was not assertively assessed and monitored.<br><br>Individual #697<br>The annual physician assessment dated 6/29/12 reported that the Individual had mild degenerative disease of the cervical spine, and the plan stated that an x-ray of the thoracic spine would be ordered, and referral to the scoliosis clinic. Review of x-ray report dated 8/29/2000 noted degenerative changes of the cervical spine, and a CT of the spine from 2011 noted prominent multilevel cervical spondylosis (degenerative spine disease). The Monitoring Team could not find routine follow-up for degenerative spine disease, despite potential adverse effects of spine disease, as reported in the ISP dated 8/3/12, noting that the Individual had sustained over 40 significant falls, without a known etiology or medical evaluation as to the cause of the falls.<br><br>Based on imaging results, the Individual has documented degenerative changes of the cervical spine, and has sustained numerous falls, of unknown etiology, and there was no evidence to suggest routine assessment for progressive degenerative spine disease. | |

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| | | Individual #47<br>The Individual underwent surgery to repair the spinal disc between levels L3 and L4 in 1995. An MRI of the lower spine was obtained in 1999 which demonstrated multiple disc bulges of the thoracic and lumbar spine, and an x-ray of the lower spine in 1996 demonstrated severe degenerative disk disease, and an imagine study of the lower spine noted central canal narrowing of the spine. The annual physician summary documented a diagnosis of congenital spinal stenosis, and degenerative disk disease with osteoarthritis of the thoracic and lumbar spine. There was no documented evidence to indicated routine assessments for progressive degenerative spine disease. The ISP dated 5/12/12 noted that the Individual had fallen three times, and was unsteady, had difficulties walking and needed to hold onto a side rail when ambulating. The ISP did not have a specific service plan to address degenerative spine disease, and only commented that the Individual had arthritis of the spine, which needed to be monitored, and pain medications given.<br><br>The Monitoring Team is very concerned with the lack of documented evidence to support that degenerative spine disease was routinely, and comprehensively assessed, lack of documentation to indicate that medical consultants were included in the management of the condition, and because the ISP did not clearly document how this condition impacts the Individual's life, how, and by whom should monitor the Individual for progressive deterioration of the spine, and how to assess for pain on a regular basis.<br><br>Individual #191<br>The Individual was noted to have significant cervical spine disease, secondary to congenital stenosis, and at the time of this evaluation clinical documents indicated that the condition was stable. This condition was clearly, and comprehensively delineated in the annual physician summary, there was evidence of appropriate imaging studies, and the Individual was closely followed by medical consultants. The ISP adequately reflected this condition.<br><br>The Monitoring Team was exceptionally pleased with the level of medical care provided for degenerative spine disease, and according to consultation reports, no special service plan were necessary to better support the Individual.<br><br>Individual #417<br>The annual physician summary dated 5/15/12 indicated a diagnosis of degenerative spine disease and compression changes at lumbar level L3. An x-ray of the spine dated 2009 noted progressive changes with degenerative process of the spine, since the previous year. A CT of the lumbar spine dated 2009 indicated multilevel degenerative changes of the spine and a bulging disc at the level of L4 and L5, which caused at least moderate spinal stenosis. There was no documented evidence to indicate that this | |

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| | | individual was followed by medical specialists, or that routine assessments for progression of degenerative spine disease were completed. The ISP dated 6/5/12 indicated that the Individual had challenges with maintaining normal gait, and required a gait belt and wheelchair for mobility. The ISP lacked specific information as to how this serious medical condition could impact the Individual's life, and what supports and services were necessary.<br><br>The Monitoring Team is concerned with the lack of documentation to support that routine assessments, monitoring for pain, and progression of degenerative spine disease was obtained, and because there was no documentation to indicate that medical specialists were consulted to help in the management of this condition.<br><br>Conclusion: Based on review of clinical documents, the Monitoring Team determined that the Facility did not provide adequate management and support for individuals with degenerative spine disease. All individuals with known or suspected degenerative spine disease must be evaluated, and carefully monitored for pain and progression, and when necessary, ensure that appropriate treatment is provided. The ISP must adequately reflect this serious condition, and delineate current and potential impact of this condition, and ensure that all necessary service objectives are in place.<br><br><u>Phenylketonuria:</u> Phenylketonuria (PKU) is a metabolic disorder that if not treated at a young age can cause mental retardation. Individuals with known mental retardation secondary to PKU may, or may not, benefit from assertive dietary and drug treatment through adulthood. The Monitoring Team reviewed the first three out of the six individuals on a list of the six known cases of PKU at the Facility (Individuals #556, #205, and #33).<br><br>Three out of the three examples (100%) indicated a diagnosis of PKU on the active problem list; two of the three (67%) included a specific medical plan on the annual physician assessment; three out of three (100%) included a recent PKU blood level; and three out of three (100%) included an ISP that clearly delineated dietary issues specific for PKU.<br><br>The Monitoring Team noted that PKU had been assessed by the primary care provider, and appropriately addressed in the ISP, and when clinically appropriate, dietary intervention was initiated.<br><br><u>Seizure Disorder:</u> Per the document request, the Facility reported that a total of 270 individuals were diagnosed with seizure disorder. Of the 270, only 14 (5%) were reported to have refractory seizures. Given the number of individuals at the Facility with comorbid intellectual disability, and seizure disorder, the Monitoring Team has concern | |

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| | | that the reported number of refractory seizure is not accurate. The current, acceptable standard for refractory seizures, as reported by P. Kwan and M.J. Brodie, Early identification of refractory epilepsy, *N Engl J Med* 342 (2000), pp. 314–39, is one or more seizures, when treated with two or more antiepileptic drugs (AEDs), within an 18 month period.<br><br>The Facility reported that no individuals experienced status epilepticus within the reporting period; however, the Facility reported that six individuals, with a known diagnosis of seizure disorder, were sent to the local emergency room for seizure activity that could not be effectively managed at the Facility. Based on this information, the Monitoring Team questions the Facility's ability to track, and trend essential clinical data.<br><br>Of the 270 individuals treated for seizure disorder, the Facility reported that 22.6% were treated with Dilantin, 13.7% were treated with phenobarbital, and 4.1% were treated with mysoline. All three medications are considered older AEDs, and when possible, Individuals should be titrated to newer medications. The Monitoring Team recognizes that some Individuals may not be safely discontinued off of these medications.<br><br>Of the 270 individuals with a diagnosis of seizure disorder, 72 (26.6%) were prescribed two AEDs; 37 (13.7%) were prescribed three AEDs; 6 (2.2%) were prescribed four AEDs; and 3 (1.1%) were prescribed five AEDs. The Monitoring Team appreciates the Facility's diligence in minimizing AED polypharmacy.<br><br>Of the 270 individuals with reported seizure disorder, 157 (58%), were evaluated by a neurologist within the reporting period. The Monitoring Team notes appropriate availability of neurology consultants at the Facility.<br><br>The Monitoring Team noted adequate neurological services for the management of seizure disorder, and that the Facility does not engage in excessive AED polypharmacy. The Facility should evaluate its practice of relying on older AEDs, and when possible consider cross tapering to newer medications.<br><br><u>Malignancy:</u> From a list of all individuals with a diagnosis of malignancy, the Monitoring Team selected the first five individuals on the list, and reviewed the annual physician summary, ISP, chronic problem progress record, last three years consultation reports, and past 12 months of laboratory data.<br><br>Of the five cases reviewed, five out of five (100%) included a comprehensive annual physician summary, that clearly delineated all relevant clinical information specific for malignancy; five out of five (100%) demonstrated timely follow-up with medical consultants, specific to the individuals treatment for malignancy; five out of five (100%), | |

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| | | demonstrated completion of all necessary laboratory and other diagnostic studies, relevant to the treatment and monitoring for malignancy; three out of five (60%) included chronic problem records that appropriately assessed malignancy; zero out of five (0%) ISPs and addendums to the ISP documented the individual's malignancy and the associated risks, how the disease impacted the individual, and supports and services that were necessary to assist the individual in managing the malignancy.<br><br>The Monitoring Team was impressed by the comprehensiveness of annual physician assessments, and clinical follow-up for malignancy. The Facility must enhance the ISP process specific to medical issues. The ISP must reflect all relevant health care issues, associated risks, how the disease impacts the individual, and necessary supports and services for each medical condition.<br><br>Diabetes: To assess the Facility's ability to manage diabetes, the Monitoring Team reviewed the annual physician summary, last two chronic problems record, most recent annual ISP and addendums to the ISP, endocrinology consultation reports, and the last 12 months of laboratory data, for the five individuals reported to require insulin to control their blood sugar level<br><br>The annual physician summary documented a comprehensive review, medical assessment, and plan specific for the management of diabetes in four out of five examples (80%); chronic problem records indicated review of diabetes, which included a physical assessment of the individual in four out of five examples (80%); a HBG-A1C blood test was routinely assessed in five out of five examples (100%); an ophthalmology consultation was routinely provided in five out of five examples (100%); appropriate consultation with an endocrinologist was provided in five out of five examples (100%); finger stick glucometer results were appropriately obtained and documented in five out of five examples (100%); HGB-A1C results demonstrating adequate glucose control of diabetes, as recommended by the American Diabetes Association, were within acceptable range (20%); the ISP comprehensively documented the affects of diabetes on the individual, and all necessary supports and services specific to diabetes, and addressed the bio-psycho-social aspects of the disease.<br><br>The Monitoring Team noted the medical providers diligence in providing very good medical care, specific to diabetes. It is obvious to the Monitoring Team that the Facility is assertively managing the medical component of diabetes well. It is essential that the ISP delineate the bio-psycho-social treatment model for diabetes, and include how the disease impacts, and is impacted by the individual's psychological well being, and how treatment includes a multidisciplinary approach that include diet, nutrition, physical activity, education, and medical management. The Monitoring Team did recognize some improvement with regards to enhanced discussion about diabetes in the ISP. | |

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| | | Specific Case Reviews<br>The Monitoring Team attended an ISP, reviewed a CLDP, and associated monitoring assessment of an Individual who transferred to the community, and observed individuals at their living area.<br><br>Individual #750:<br>The Monitoring Team attended the annual ISP meeting on 10/9/12. Nurse and direct care staff reported a long history of worsening diarrhea, with multiple loose and water bowel movements everyday. Importantly, the individual was treated in the past for electrolyte imbalance, which the Monitoring Team believed may have been caused by diarrhea, among other conditions. The individual was diagnosed with chronic constipation on the current comprehensive nursing assessment dated 7/3/12, and on the most recent active problem list, and annual medical assessment. None of these assessments commented on chronic diarrhea. The Individual had multiple medical issues that placed the individual at risk for diarrhea, including a change in tube feeding formula, which could cause diarrhea, a known medical diagnosis of diverticulosis, a report of a history of dysmotility, a diagnosis of constipation, quadriplegia, and chronic treatment with methylcellulose; all of which can manifest a fecal impaction, and resultant overflow incontinence.<br><br>During the annual ISP meeting, the team completed its discussion on risks for constipation, and GI issues; however, the team never asked the physician, or nurse what the cause of the chronic and severe diarrhea was. The physician in attendance did not assertively participate in the team discussion, and did not offer an explanation for the diarrhea, but mentioned that he would have to review the record, as the individual had GI consults in the past. The Monitor Team was concerned that the team was not well informed about potential serious medical issues related to the individual's chronic diarrhea, a lack of a meaningful workup for diarrhea, and lack of assertive participation at the ISP by physician services.<br><br>Also of concern was the lack of a meaningful discussion on other GI related issues, including discussion regarding the diagnosis of hemorrhoids, GERD, and chronic gastritis.<br><br>Individual #505:<br>The Monitoring Team reviewed the Individual's community living discharge plan (CLDP), annual medical assessment, and addendum to the annual medical assessment, medical consultation reports, and integrated progress notes.<br><br>The individual was diagnosed at the Facility with many diagnoses, including diabetes mellitus that required very close monitoring; high blood pressure and coronary heart | |

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| | | disease that required close monitoring; chronic renal insufficiency that require specialized diet, and follow-up with a medical specialist; obstructive apnea that required the use of a device to help the individual breath while asleep, and close monitoring by staff; bilateral cataracts and recommended surgical intervention; several gastrointestinal issues, including gastritis, hemorrhoids, and diverticulosis, that required close monitoring.<br><br>The Monitoring Team noted several important, and concerning issues related to the development and implementation of the CLDP, and related supports and services provided at the Facility, versus what was determined necessary at the time of transfer to the community agency, and post move monitoring.<br><br>The individual was known to be non-compliant at times with the use of a CPAP machine, while at the new home. Post move monitoring noted that agency staff would have to regularly remind the individual to replace the CPAP machine, during the night. Without consistently using the CPAP machine, the individual would be at risk for worsening behavioral issues, and potentially serious cardiovascular issues, such as arrhythmias and possibly death. The Monitoring Team did note that the individual was found dead in bed during the early morning hours. The consistent use of the CPAP machine was especially important for this individual because of known coronary artery disease. Documentation indicated that lack of compliance with the CPAP machine was not effectively addressed by the post move monitor or Facility medical staff.<br><br>It was essential that the individual followed up with an endocrinologist, for significant diabetes, and the need for close monitoring of glucose control and insulin administration. The individual had not been scheduled to see an endocrinologist by the time of the 90 day post move monitoring assessment.<br><br>The individual was known to have significant cardiovascular disease, and the annual medical assessment commented on the need to monitor closely for chest pain, and other signs and symptoms of cardiovascular disease. This was not communicated to the agency, nor were such symptoms monitored by the agency. Also, the Facility did not refer the individual for cardiology consultation, prior to discharge from the Facility.<br><br>The individual was to be referred to a psychiatrist; however, at the time of the 90-day post move monitoring, a community psychiatrist had not evaluated the Individual. It was especially important for follow-up with a psychiatrist to conduct a medication assessment, because of the serious risk factors, including obstructive apnea, and heart disease, and the sedating medications the individual was on. Oversedation, especially at night could hasten death in a person with such a condition. | |

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| | | There were several important issues that required very close monitoring including blood glucose levels, blood pressure, signs and symptoms of heart disease, weekly weights, worsening skin lesions secondary to diabetes and peripheral vascular disease, and the quality and quantity of the individual's diet. In all cases, specific issues were not assessed during the post move monitoring. The only issues assessed were that the tracking sheets were completed for blood pressures and blood glucose levels, and that scales were in place and being used. Importantly, there was no indication that the individual's weights or glucose results were actually assessed by medical professionals from the Facility, to ensure that the agency was adequately addressing such issues.<br><br>It was important that the individual's nutritional needs were being met; however, there was no indication that post move monitoring assessed actual meals being prepared or served appropriately. The individuals diet was critical in the health and wellbeing of this individual.<br><br>The Monitoring Team was extremely concerned that the Facility physician did not participate at the 90 day IDT review, dated 9/6/12, twelve days before the individual expired.<br><br>The Monitoring Team is seriously concerned with the post move monitoring and CLDP processes. The Monitoring Team believes that the CLDP did not clearly delineate the necessary clinical supports and services to ensure safe transition, and that post move monitoring was not effective in ensuring that the individual health and welfare was being appropriately addressed by the accepting agency.<br><br>The Monitoring Team recommends the Facility review how Facility staff participate in development and monitoring of health and medical supports, and determine processes to assign Facility staff responsibility for ensuring community physicians and other clinicians who will provide services and treatment are fully aware of health needs of individuals. The Facility should ensure the CLDP assigns monitoring of complex and significant health supports to appropriate Facility staff, including clinicians when appropriate.<br><br><u>Individual #734</u><br>The Monitoring Team observed the individual at the Individual's home on two occasions. During the afternoon the individual was noted to be upright in a wheel chair, eyes open but appeared drowsy. The individual had significant and chronic skin changes of the lower extremities, and the upper extremities appeared edematous, and bright red, and purple. There was noted papule rash over the neck and trunk. The second observation, which occurred at approximately 6:30 p.m., demonstrated the individual in bed, and appearing lethargic. The Monitoring Team requested that the unit physician assess the | |

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| | | individual, and later that evening the individual became more responsive. Review of the record indicated that the Individual was receiving scheduled doses of Benadryl, which may have been contributing to the lethargy.<br><br>Review of clinical records indicated that the Individual developed an allergic reaction on or around 9/10/12. Although the physician saw the individual, this reaction continued without a comprehensive assessment to determine the etiology of the allergy, and only palliative treatment with Benadryl, and topical steroids was provided. The treating physician did not write an order for a dermatology consultation until 10/2/12, and an appointment date of 10/18/12 was scheduled.<br><br>The Monitoring Team was concerned over the individual's lethargic presentation, and multiple staff at the living area, including nursing staff, were unable to inform the Monitoring Team if the lethargy was normal or not for the individual. Given the individual was prescribed a sedating medication, Benadryl, and had significant medical conditions, including pulmonary stenosis, and severe cardiac conditions, the functional status of the individual should be known by all staff who support the individual. If the staff cannot determine and report whether the status of an individual is or is not normal, they cannot know when to report a change of status or the possibility of an adverse drug reaction (please note in Provision N6 the concern of the Monitoring Team about possible under-reporting of adverse drug reactions).<br><br>The Monitoring Team is very concerned with the overall treatment of this individual by the medical, nursing, and direct care staff at the living area. The allergic reaction should have prompted an immediate medical evaluation to identify the cause of the allergy; the issue of episodic lethargy should have been well documented and addressed in the clinical record, and staff should have been able to demonstrate an understanding of the Individual's baseline condition.<br><br><u>Conclusion</u><br>Based on review of clinical documents, and observations of Individuals who reside at the Facility, the Monitoring Team determined that the Facility remained not in compliance with Provision L1, of the Settlement Agreement. Multiple findings, in areas of acute, and chronic care management, preventive health measures, participation with the IDT process, and failure to adequately participate in community living plan discharge process (CLDP) and monitoring of clinical indicators of those transferred to the community, were not effective in supporting the Individuals who reside at the Facility. Compliance will require that the Facility comprehensively and immediately address acute care issues, with regular follow-up of individuals through resolution; provide effective management and regular assessments of chronic care conditions, especially for those conditions that | |

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| | | are commonly associated in individuals with developmental disabilities; fully participate in the IDT process and ensure that all health care issues are well communicated to the team; and ensure that all clinical supports, and services are identified and in place during CLDP meetings, and closely monitored following transfer to the community. | |
| L2 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement. | To comply with Provision L.2, the Facility adopted the DADS medical provider quality assurance audit process, and conducts both internal and external audits quarterly. The Facility contracted with an external physician, who was certified in medical quality assurance, to conduct their internal audits. The most recent internal and external audits were performed in August 2012. All practicing medical providers were assessed during both internal and external audits. The Monitoring Team was made aware that to enhance the audit process, and ensure that the provider's clinical performance was assessed, the Facility included the updated DADS process, by including a specific medical management performance audit. The Monitoring Team also reviewed the Facility's mortality review process.<br><br><u>Medical Provider Audits</u><br>For round six of the external medical provider audits, which were completed in August of 2012, all eight medical providers were assessed, and eight out of eight (100%), achieved greater then 80% on non-essential audits, and two out of eight (25%) achieved the required 100% on the essential audits.<br><br>The Monitoring Team was provided medical management audits for only six of the eight medical providers for round six of the external and internal medical provider audits. Provider #1 was assessed for urinary tract infections (UTI); Provider #3 was assessed for seizure disorder; provider #4 was assessed for seizure disorder; provider #5 was assessed for constipation and UTI; provider #8 was assessed for seizure disorder, UTI and constipation; and provider #9 was assessed for constipation. The Facility did not provide a summary of the outcome scores for the providers' performance on the medical management component; hence, the Monitoring Team was unable to assess the providers' performance on the medical management component.<br><br>There was a reported 96% inter-rater reliability between the Internal and External Audit findings, which indicated that the evaluation process was well standardized.<br><br>For each provider there was a quality assurance initiative developed for identified areas of deficiencies. Out of the 47 deficient areas identified for the external audit review, 30 (63%) were completed by the time of this review. There were a total of three QA initiatives developed for the external medical management audits, and one out of three (33%) had been completed by the time of this review. There was no quality assurance data provided with regards to internal audits, except for nine issues that were identified | Noncompliance |

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| | | for medical management deficiencies, and only three out of nine (33%) were completed by the time of this review.<br><br>The Monitoring Team reviewed the specific medical management audit tools for constipation, seizure disorder, and UTI, and determined that the assessment tools to assess the providers' clinical performance should be reviewed and revised to be more complete. The tools did not enable a review, or assessment of actual treatment outcome for each of the conditions. Medical management audits were developed to assess clinical outcomes, however, the current indicators focused on processes and not outcomes. The audits should assess both. For example, the tool used for seizure disorder did not determine if seizures were better controlled from the previous year, and for constipation, was there any adverse outcome secondary to constipation during the previous year, and did the individual require prn medication for bowel management. The Monitoring Team has concerns with the validity of specific questions on the tools, for example, the tool for UTI assesses if the provider ordered a urology consult if a male had more then one UTI in a year may be unnecessary, and the provider should not wait until a female has more then three UTIs in a year before getting a consult in most cases.<br><br><u>Mortality Review Process</u><br>The Nurse Investigator continued to maintain comprehensive tracking system for tracking compliance with the Clinical Death Review Committee and Administrative Death Review Committee Policies. The tracking systems showed 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. As found in previous reviews the Texas Department of Aging and Disability's Death Review Policy had not been updated.<br><br>Since the last review, three deaths had occurred at the Facility. This was the Facility's lowest incidence of death occurring over a six month period since the Settlement Agreement began. General findings included:<br>• Of the three deaths, the average age was 67.3 years (ages varied from 61to 73 years of age).<br>• A review of the Facility's Clinical Death Review Committee and Administrative Death Review Committee Tracking Reports indicated that three of three (100%) death reviews complied with the Facility's Clinical Death Review Committee and Administrative Death Review Committee Policies. This showed continued improvement.<br>• One of the three (33%) deaths had an autopsy completed.<br>• Zero of three (0%) were reported as unusual deaths.<br>• Three of three (100%) had Unusual Incident Reports (UIRs) completed related to the | |

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| | | deaths.<br>• Three of three (100%) deaths occurred at an outside facility. Two of the deaths occurred at local hospitals and one death occurred in a Long Term Acute Care Facility.<br>• Three of the three decedents had Do Not Resuscitate (DNR) orders signed.<br>• The cause of individuals' deaths, as listed on the Death Certificates, are listed in the chart below:<br>1. Primary Cause of Death: Septic Shock<br>Secondary Cause of Death: Urinary Tract Infection<br>Tertiary Cause of Death: Obstructing Nephrolithiasis<br>2. Primary Cause of Death: Pneumonia<br>Secondary Cause of Death: Dysphagia<br>3. Primary Cause of Death: Primary Cause of Death: Toxic Megacolon<br><br>The Clinical Death Review Committee membership, according to policy, included the: Medical Director/Designee; Director of Nursing Services/Designee; Investigating Officer (Nurse); Attending Physician; Nurse Practitioner or Primary Physician/Nurse Practitioner if different from the Attending Physician/Nurse Practitioner for the deceased individual; visiting Physicians from other State Supported Living Centers; a Physician not employed as a staff Physician by the Department of Aging and Disability Services, and the Nursing Supervisor (Nurse Case Manager) responsible for the specific residential area where the deceased individual lived.<br><br>The Administrative Death Review Committee membership, according to policy, included the: Facility Director, Medical Director, Chief Nurse Executive, and Public Representative.<br><br>The Nurse Investigator continued to maintain a tracking system for compliance with the Facility's Clinical and Administrative Death Reviews Committees and resulting recommendations through to resolution for each death. The Monitoring Team reviewed the Clinical and Administrative Death Review Committees' Recommendation Tracking Logs for each of the three deaths. A review of the three deaths' recommendations made by the Clinical and Administrative Death Review Committees indicated that recommendations for two deaths had been carried through to resolution. The most recent death's recommendation was not yet completed and will be reviewed at the next compliance review. Based on the review of the recommendations, while all were appropriate, they were limited to the Medical Director, Facility Director, and Nurse Investigator. There were no recommendations related to nursing services, other disciplines, or systemic recommendations. The purpose of conducting death reviews is to ensure thorough, systemic, and integrated death reviews are conducted in order to | |

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| | | provide information that helps the Facility improve services to maintain health and safety.<br><br>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 and systemic discussions and recommendations, in addition to providing consistency among the reviewers.<br><br>The State Office had not yet revised 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.<br><br>The Facility had not conducted a Mortality/Morbidity Review and Analysis of longitudinal data related to deaths in order to track and trend systemic issues, develop corrective action plans, or the efficacy of the corrective actions.<br><br><u>Conclusion</u><br>The Facility continued to enhance the medical provider audit process by ensuring that an external physician who was certified in medical QA performed the internal audits. Meaningful action plans were developed for medical provider audits that were assessed to be deficient, and quality assurance initiatives were developed to ensure that action plans were completed; however, the action plans were not addressed timely by the provider. The Monitoring Team determined that the medical management component of the medical provider audit process was determined to need further review and revision. Compliance will require that the Facility review the medical management audits, and ensure that they identify specific treatment outcome data that reflects the provider's clinical performance. The Monitoring Team also expects that all providers will be assessed for clinical performance during the medical provider audit process, and that providers will be assessed for several medical management performance outcomes, during each review process.<br><br>The mortality review process continued to significantly improve by the addition of an external physician who regularly attended all mortality reviews, and by ensuring a more robust review of deaths. Compliance will require enhanced physician and nursing staff participating in the mortality review process by probing for a more detailed root cause analysis of each death. Also, the Facility must develop a mechanism to effectively track and trend mortality review data, and ensure full implementation of meaningful recommendations. | |

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| 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. | To assess the Facility's process to develop and implement a medical quality improvement system to enable assessment of clinical outcomes, and facilitate systems improvement measures, the Monitoring Team discussed the Facility's progress with the medical director, who informed the Monitoring Team clinical indicator data was being collected for analysis by the QA department, and was reported at the physical nutrition management committee meetings (PNMC). The Facility provided a table of clinical indicators, with the reviewing authority and frequency of review of each. Items from the table of clinical indicators might be reviewed monthly, quarterly, annually, or upon request. This table provided an easy reference that could be used to identify who would have information and to guide auditing for documentation of review. One table, for apartment 512C, showed the ability of the Facility to break down the information in a way that will provide essential information in planning improvements. However, the Facility did not provide information on monitoring to ensure reviews took place, other than the reports provided to the QA/QI Committee.<br><br>The Facility also provided sets of data on infections, decubitus ulcers, and pneumonia; these data were not accompanied by any documentation of review, assessment, and actions. Furthermore, the Facility reported a successful example of an improvement action taken as a result of review of clinical indicators. Data showed an increase in urinary tract infections. The Facility reviewed the data and implemented actions including retraining and monitoring on proper cleaning and washing of women who have a toileting accident and on handwashing, as well as ensuring adequate fluid intake.<br><br>Although the table of indicators, the data provided, and the example of action demonstrated the Facility had taken a major step toward using such clinical indicators of efficacy to lead toward improved services, it was not clear that these indicators were regularly used as part of an organized and routine process of medical quality assurance that initiates outcome-related inquiries, initiates corrective actions, and monitors to ensure remedies are achieved.<br><br>To further assess the Facility's ability to maintain a medical quality assurance process, the Monitoring Team requested copies of all PMNC minutes, and all data, graphs, and analysis of data used for medical quality assurance, and system improvement.<br><br>The Monitoring Team was provided copies of PNMC minutes for the following meetings:<br>• April 5, 2012<br>o No QA data, or analysis was included in the PNMC minutes.<br>• May 24, 2012<br>o Data on infection control was presented, which demonstrated decrease in respiratory infections, and increase in C-diff and skin infections.<br>o Data was also presented on the incidence of decubitus ulcers, which | Noncompliance |

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| | | demonstrated an increase of decubitus ulcers in the second quarter of 2012. There was no associated analysis for decubitus ulcers.<br>• June 14, 2012<br>o Although no data were attached to the minutes, minutes reflected that PNMC reviewed data on several conditions and discussed pneumonia and falls prevention.<br>• June 28, 2012<br>o No appreciable review of data<br>• July 12, 2012<br>o Although no data were attached, minutes reflected discussion of data on pneumonia, emergency room visits, decubitus ulcers, hospitalizations, and falls.<br>• July 19, 2012<br>o No appreciable review of data<br>• August 2, 2012<br>o No appreciable review of data<br>• August 9, 2012<br>o There was an excellent discussion on pneumonia, and associated action plan to bring in a pulmonologist to provide in-services, and to help manage recurrent pneumonia cases.<br>o Data on diabetes was presented, which included an analysis, and excellent discussion. It was noted that hyperglycemic events increased, while hypoglycemic incidence decreased.<br>• August 18, 2012<br>o Only a limited discussion about pneumonia; however, no data, or analysis was presented<br>• August 23, 2012<br>o No discussion on any Medical QA data<br>• September 6, 2012<br>o There was some discussion on infection control, aspiration pneumonia, UTIs and ER visits; however, no data or specific analysis was presented at this meeting.<br>• September 13, 2012<br>o Detailed discussion on pneumonia with associated action plan.<br>o No specific data was reported on medical QA, but it was reported that the Facility is using a variety of forms and not just the universal monitoring form get more information; minutes indicated these forms will be reviewed to determine what data to pull for PNMC review. It is positive to find that a variety of data are being gathered; the Facility must determine what data need to be standardized to ensure | |

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| | | information is comparable and can be used to make decisions.<br>The Monitoring Team attended the PNMP Committee quarterly meeting on 10/11/12 where the Wound Care Nurse presented a summary of skin integrity issues for June 2012 through September 2012. Detailed information can be found in Provision M1.<br><br>Summary<br>Following review of medical quality assurance data, and associated graphs, analysis, and PNMC meeting minutes, and because there was no associated policy for the Facility's medical quality assurance process, the Monitoring Team determined that the Facility was not in compliance with Provision L.2. Compliance will require that the Facility develop a comprehensive medical quality assurance process, that reviews regularly data of common and serious medical conditions, assesses the data to determine issues that need to be addressed, and is used to enhance clinical practice and outcomes at a system level. | |
| 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. | The Monitoring Team reviewed the Facility's policy and procedure for medical care, guidelines for barium swallow studies, and procedure for seizure management. The Monitoring Team also discussed progress with clinical pathways with the medical director.<br><br><u>DADS Medical Care Policy: 009.1, dated 9/6/12</u><br>The medical director reported to the Monitoring Team that the Facility continues to develop a draft policy, and procedure for medical screening and routine evaluations; hence, a Facility policy for medical care is not available.<br><br>The only policy and procedure that the facility has related to medical practice, is the DADS State Policy for Medical Care, which was updated on 9/6/12. The Monitoring Team reviewed the updated policy and noted the following issues:<br>• Physicians were not routinely following policy when addressing acute care issues. For example, the Monitoring Team failed to identify any IPN or medical assessment that documented pertinent negative examination findings, which is standard of care practice. The development of a differential diagnosis was also not observed following assessment of acute care cases.<br>• Physicians were not routinely following up on acute medical issues per policy.<br>• Physician orders and assessments did not detail monitoring expectations from nursing staff. For example, recommendations for monitoring were vague, such as "monitoring for worsening", and did not provide specific examples of what to monitor.<br>• Physicians were not regularly following policy on the management of chronic conditions. The Monitoring Team noted that chronic care conditions were not assertively being addressed on a regular basis. For example, individuals with | Noncompliance |

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| | | cerebral palsy were not regularly assessed for progression of musculoskeletal co-morbidities, individuals with degenerative spine disease were not regularly assessed for progression, and rarely did a physician document on efficacy of treatments for chronic care issues<br>• The Monitoring Team noted that the policy indicated that the Facility may obtain a consent for initial and booster doses for influenza vaccine. The policy should indicate that consent is required annually for influenza vaccine.<br>• Specific to vaccinations, the policy should reflect current CDC guidelines, especially with regard to documentation of immunization status. For example, the Facility must have a process to determine what type of documentation is acceptable to verify individuals' immunization status.<br>• The Facility is not following policy with regard to data collection and analysis. For example, there was no local policy and/or procedure that delineated the Facility's tracking and trending of clinical indicators for quality improvement initiatives.<br><br><u>Policy and Procedure for Seizure Management</u><br>This policy governing seizure management was not dated, and did not include a policy number. The Policy noted several areas of concern with the policy:<br>1. The policy did not comment on the use of "older" AEDs, such as phenobarbital, Dilantin, and mysoline.<br>2. The policy did not comment of the use of vagal nerve stimulators.<br>3. The Policy did not specifically address Facility practice standards regarding monitoring of AED drug levels.<br>4. The Facility had under-reported the number of individuals who had refractory seizures. Also, the Facility may want to refer to the medical literature to update its definition of refractory seizures. P. Kwan and M.J. Brodie, Early identification of refractory epilepsy, *N Engl J Med* 342 (2000), pp. 314–39, reports that refractory seizure disorder is one or more seizures, when treated with two or more antiepileptic drugs (AEDs), within an 18 month period.<br><br><u>Clinical Pathways</u><br>The Monitoring Team was informed that Clinical Pathways were not updated since the previous Monitoring Team Visit, and no new pathways had been developed. The Monitoring Team is concerned that without guidelines for the more serious medical conditions that commonly occur in individuals with developmental disabilities, such medical conditions will not be effectively managed by the medical staff.<br><br><u>Conclusion</u><br>Because the Facility did not follow the DADS policy and procedure on Medical Care, and | |

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| | | did not have or did not follow policies, procedures, and, or guidelines for medical operations, including medical quality assurance processes, the Monitoring Team determined that the Facility is not in compliance with Provision L.4. Compliance requires the development and implementation of policies, procedures, and/or guidelines that will reflect the Facility's practices with regards to medical services and medical quality assurance processes. The Monitoring Team strongly recommends that meaningful and effective clinical pathways be developed for the more serious medical conditions that occur in individuals with developmental disabilities. The policy and procedure for seizure management should be updated to reflect current practice standards. The DADS policy on medical care should updated it policy to reflect CDC recommendations regarding immunization practices. | |

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

1. Develop a mechanism to timely and completely track and trends relevant clinical data. (Provisions L.1, L2, L3, and L4)
2. Develop specific CME events for practitioners that address common and serious conditions that commonly occur in people with developmental disabilities. (Provision L.1)
3. Enhance preventative measures for decubitus ulcers. (Provision L.1)
4. Improve on providing timely preventive health screening procedures, such as mammograms and screening colonoscopies. (Provision L.1)
5. Ensure that individuals are screened for syndromal conditions, and that all potential manifestation of syndromes, such as cardiac, hematological, and degenerative processes of the spine and hips, are regularly screened in persons with Down Syndrome. (Provision L.1)
6. Review the current practice of using Nasal Calcitonin for individuals with Osteoporosis. (Provision L.1)
7. Ensure that all individuals with low bone density are evaluated for the etiology of their low bone density, before diagnosing osteoporosis and initiating treatment for osteoporosis. (Provision L.1)
8. The Facility must enhance its practice standard with regards to evaluating, treating, and monitoring degenerative spine disease. (Provision L.1)
9. Evaluate the use of older AEDs, and when clinically indicated, consider cross tapering to more modern AEDs. (Provision L.1)
10. Ensure that diabetes mellitus is treated in the context of a multidisciplinary approach, that addresses the bio-psycho-social aspects of the individual's life. (Provision L.1)
11. Physicians must enhance their participation at IDT meetings. (Provision L.1)
12. It is imperative that physicians address all clinical issues at CLDP meetings, and ensure that all medical issues are clearly delineated, and that all necessary supports and services have been identified and arranged, before transfer out of the Facility. (Provision L.1)
13. Physicians must review all medical data and outcomes of individuals transferred to the community, and participate at their post move monitoring meetings. (Provision L.1)
14. Physicians must regularly follow-up on all medical issues, including acute care conditions, through resolution. (Provision L.1)
15. Develop a system to track and trend mortality review data. (Provision L.2)
16. Review and document corrective actions, quality assurance initiatives developed through the mortality review process, and status and effectiveness of implementation. (Provision L.2)
17. Develop a policy and procedure that reflects the Facility's mortality review process. (Provision L.2)
18. The medical management component of the medical provider audits must be improved to ensure necessary data is collected that enables an assessment of the provider's clinical performance. Medical providers should be assessed for several clinical outcomes, during the medical provider

audit process, including the six conditions currently assessed. (Provision L.2)

19. The Facility must enhance its medical quality assurance process to ensure that all relevant clinical indicators have been identified, and are regularly tracked, analyzed, reported on, and that action plans are developed to help ensure system improvement. (Provision L.3)
20. Develop policy and procedure for the Facility's medical quality assurance process. (Provision L.3)
21. Physicians must adhere to policy and procedures. (Provisions L.1, and L.4)
22. Develop and implement additional clinical pathways that are efficient, and efficacious, for the more serious medical conditions that commonly occur in individuals with developmental disabilities. (Provision L.4)
23. Update the Facility seizure management policy to reflect current practice standards. (Provision L.4)
24. The DADS policy on medical care should reflect the CDC recommendations for immunization practice. (Provision L.4)

| SECTION M: Nursing Care | |
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| 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:**<br>**Documents Reviewed:**<br>1. DSSLC Section M Self-Assessment, 9/24/12<br>2. DSSLC Section M Action Plan, 9/24/12<br>3. DSSLC Section M Presentation Book<br>4. DADS Division of Nursing, Quarantine Protocol, Reviewed/Revised Date: 9/1/09<br>5. Texas Department of Aging and Disability Services (DADS) Emergency Response, Policy Number: 044.2, Effective Date: 9/11/11<br>6. DADS Division of Nursing, Quarantine Protocol, Reviewed/Revised Date: 9/1/09<br>7. DADS Nursing Protocol: Seizure Management Guidelines, Date: February 2011<br>8. DSSLC At Risk Individuals, Policy Number: CM-14, Revised: 3/25/12<br>9. DADS At Risk Individuals, Policy Number: 006.3 Effective 8/24/12<br>10. DADS Procedure: Medication Administration Observation Guidelines, Date: October 2012<br>11. DSSLC Pharmacy Metabolic Syndrome Risk Monitoring Policy, Pharmacy Policy #47, revised: 9/15/12<br>12. DSSLC Pharmacy and Therapeutics Committee, Policies and Procedure Manual Committees and Councils-05, Dated: 2/1/10<br>13. DSSLC Medication Variance Tracking and Procedures, Pharmacy Policy, #27.1, Revised Date: 2/15/12<br>14. DSSLC Guide to Medication Storage, Pharmacy Policy, #36, Dated: 6/21/11<br>15. DSSLC Procedure for Inpatient Medication /dispensing, Pharmacy Policy, #39, Revised Date: 9/10/12<br>16. DSSLC Procedure for all Medication Orders, Pharmacy Policy, #21, Date: 9/10/10<br>17. DSSLC Procedure for Medication Orders for Individuals Attending School, Pharmacy Policy #22a, Dated: 5/21/11<br>18. DSSLC Procedure for Medication Orders on Furlough, on Community Activities, or Discharge, Pharmacy Policy, #22, Revised Date: 6/15/12<br>19. DSSLC Procedure for Patient Drug Refill, Pharmacy Policy, #23, Date: 5/7/07<br>20. DSSLC Medication Variance Committee, Policies and Procedure Manual, Committees and Councils, #23, Date: 8/9/11<br>21. DADS Procedure: Medication Administration Guidelines, Date: February 2011<br>22. DSSLC Policy for Non-crushable Medication, Pharmacy Policy #38, Date: 5/30/11<br>23. DSSLC Division of Nursing, Nursing Management of Diabetes, Draft, no date<br>24. DSSLC Nursing Department Organizational Chart<br>25. DSSLC Nursing Standardize Procedures-Protocols-Guidelines Training Tracking Report, Updated: 10/11/12<br>26. DSSLC Nursing Education October 2012 Training Calendar<br>27. DSSLC Mosby's Physical Examination Course Schedule for Registered Nurses<br>28. DSSLC Nursing Staffing Numbers Analysis for the last six months<br>29. DSSLC Nursing Full Time Equivalents (FTEs) for 2012<br>30. DSSLC Summary of Nursing Staffing Reports for the last six months<br>31. DSSLC RN Case Managers Roster, 9/13/12<br>32. DSSLC Nursing Staffing Patterns by Shift for Residential and Infirmary Services, September 2012<br>33. DSSLC 2012 Nursing Overtime Hours for the last six months |

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| | 34. DSSLC 2012 Contract Nursing Hours for the last six months<br>35. DSSLC Schedule of Meetings with Nursing Participation for the Week of October 8 through October 12, 2012<br>36. DSSLC Nursing Department Meeting Minutes for the last six months<br>37. DSSLC Nursing Department's Duties in Relation to Our Facility Priorities for each Administrative, Management, and Specialty Nurses.<br>38. DSSLC List of Monitoring Completed by Nurses<br>39. DSSLC Universal Monitoring Tool Instruction and Sample Tool<br>40. DSSLC Section M Morning Process, Revised 10/4/12<br>41. DSSLC Guidelines for Nurse Manager QA/QI Monitoring Tool, Updated: 4/27/12<br>42. DSSLC Instructions for Audit of SOAP Documentation and Sample Audit Tool<br>43. DSSLC Sample of 18 Blank Protocol Card Monitoring Tools<br>44. DSSLC QA/QI Council Meeting Minutes, 8/24/12 and 9/28/12<br>45. DSSLC Blank Nurse Manager Monitoring Tool<br>46. DSSLC Examples of Completed Nurse Manager Monitoring Tools for August 2012 and September 2012<br>47. DSSLC Skin Integrity Summary June 2012 through September 2012<br>48. DSSLC Infirmary – 24 Hour Shift Report for 10/8/12<br>49. DSSLC Physical Nutritional Management Committee Minutes, 9/13/12 and 10/4/12<br>50. DSSLC Physical Nutritional Management Team Evaluation for Pre-Discharge for Individual #737<br>51. DSSLC Diabetic Management, Incidence of Hypoglycemia and Hyperglycemia Chart, October 2011 through September 2012<br>52. DSSLC Diabetic Management Summary for August 2012<br>53. DSSLC Glucometer Monitoring Records by Units/Infirmary for August 2012<br>54. DSSLC Improvement in Care for Individuals in the Hospital Setting Report<br>55. DSSLC Emergency Response Committee Membership List<br>56. DSSLC Infection Control Environmental Surveillance Reports for the last six months<br>57. DSSLC Infirmary Admissions for the last eight months<br>58. DSSLC Emergency Room Visits and Hospital Admissions reports for the last six months<br>59. DSSLC Chart of Hospitalizations for 2012, 2011 and 2012<br>60. DSSLC Emergency Cart Check Reviews and Completed Emergency Equipment Walkthrough Checklists for last six months<br>61. DSSLC List of Emergency Drill Instructors<br>62. DSSLC List of Location of Facility's Medical Emergency Equipment, Automated Defibrillators (AEDs), Suction Machines, and Oxygen<br>63. DSSLC Emergency Drill Response Reports/Graphs for the last eight months<br>64. DSSLC Completed Emergency Drill Checklist for the last six months<br>65. DSSLC Fire Drill Orientation Competency-based Training Material, Date: 4/16/12<br>66. DSSLC Responding to Hazards and Emergencies Competency-based Training Material<br>67. DSSLC Incident Management Team Meeting Minutes for the last six months<br>68. DSSLC Emergency Drill Meeting Minutes, 6/20/12 and 8/30/12<br>69. DSSLC Competency Training and Development (CTD) Due/Delinquent Report for Cardiopulmonary Resuscitation (CPR) Basic, Date: 9/18/12 |

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| | 70. DSSLC Pandemic Respiratory Infectious Disease Readiness Plan<br>71. DSSLC Antibiogram/Epidemiology Reports, February through July 2012<br>72. DSSLC Infection Control Prevention and Practices Competency-based Training Material, Date: 12/23/11<br>73. DSSLC Infection Control Newsletter, 4/24/12 and 9/27/12<br>74. DSSLC Infections by Type Monthly Reports and Corrective Actions, January 2012 through September 2012<br>75. DSLC Infection Control Aspiration Pneumonia/Pneumonia Summary from May 2012 and September 2012<br>76. DSSLC Infection Control – Analysis of Communicable Disease Data from May 2012 through September 2012<br>77. DSSLC Infection Control – Pseudomonas Infection from March 20122 through August 2012 and Corrective Action Taken Since March 2011<br>78. DSSLC Infection Control – Reports Related to Trends of Employee Infections<br>79. DSSLC Process for Infection Control Monitoring<br>80. Infection Control Monitoring Data for past six Months and Corrective Actions Taken<br>81. DSSLC 2012 Immunization Tracking Reports<br>82. DSSLC Competency Training and Development (CTD) Due/Delinquent Report for Infection Control Refresher Training, Date: 9/12/12<br>83. DSSLC 2011 Summary Report for Individual Flu Vaccinations<br>84. DSSLC 2012 Summary Report for Individual Tuberculosis (TB) Immunizations<br>85. DSSLC 2012 Summary Report for Employee TB Immunizations<br>86. DSSLC 2011 Summary Report for Employee Flu Vaccinations<br>87. DSSLC 2012 Summary Report for Employee Hepatitis B Vaccinations<br>88. DSSLC Process for Type and Frequency of Infection Control Monitoring<br>89. DSSLC Summary of Infection Control Data and Corrective Action Plans for: Home Surveillance, Handwashing, Refrigerator Logs, 24 Hour Nursing Reports, and Antibiotic Reports to the Pharmacy<br>90. DSSLC Infection Control Committee Minutes, 11/17/11, 4/30/12, and 9/28/12<br>91. DSSLC Procedure/Process and List of Nursing Monitoring/Audits Other that Nursing Care Monitoring Tools<br>92. DSSLC Revised ISP, Risk Rating Form, and Integrated Health Care Plan Training Documents<br>93. DSSLC Fall Prevention Program Resource Manual, May 2012<br>94. DSSLC Pharmacy and Therapeutics Committee Minutes 4/3/12, 4/24/12, 5/29/12, 6/26/12, 7/24/12, and 9/5/12<br>95. DSSLC Medication Variance Committee Meeting Minutes, Dates: 4/4/12, 5/30/12, 6/20/12, 7/18/12, and 8/15/12<br>96. DSSLC Completed Medication Administration Observations for Units and Facility for the last eight months<br>97. DSSLC Medication Variance Tracking and Reports for the past year, to date DSSLC Nursing's Unit Medication Variance Committee Meeting Minutes, March 2012 through August 2012<br>98. DSSLC Medication Variance Committee Report March 2012 through August 2012<br>99. DSSLC 10 Most Recent Medication Variances |

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| | 100. DSSLC Community Placement Meeting Minutes for Individuals #354, 2/3/12<br>101. Sample of Records of Hospitalized for Individuals #414, #673, #42, #220, #30, #211, and #737<br>102. Sample of Seizure Records and Corresponding Integrated Progress Notes for Individuals #554, #499, #674, #578, and #37<br>103. Sample of Acute Care Plans and Corresponding Documentation of Active Infections for Individuals #187, #85, #352, #164, #103, #517, and #681<br>104. Sample of Diabetic Records and Corresponding Documents for Individuals #367, #401, #210, #611, #526, #411, and #492<br>105. Sample of Acute Care Plans and Corresponding Documentation of Active Skin Integrity Issues for Individuals #365, #177, #551, #55, #727, #289, #533, #411, #355, 242, and #392<br>106. Sample of six of the most recently completed Integrated Risk Rating Forms and Action Plans for Individuals #438, #298, #175, #192, and #19.<br>107. Sample of Nursing Assessments for Community Placement for Individuals #236, #683, #458, #771, #287, #494, #354, #505, #275, #258, #493, and #197<br>108. Sample of September 2012 Aspiration Trigger Data Sheets and Corresponding Integrated Progress Notes for Individuals #715, #478, #639, #11, #134, #187, #503, #92, #460, #211, #507, #37, #461, #423, #352, #699, and #3<br>109. Sample of 12 Recently Integrated Risk Rating Form and Risk Action Plans for Individuals #123, #622, #438, #298, #, 152, #19, #192, #175, #788, #262, #231 and #633<br>110. Sample of Community Living Discharge Plan - Nursing Assessments for Individuals #287, #494, #354, #505, #258, #493, and #197<br>111. Sample of Admission, Annual and Quarterly Comprehensive Nursing Assessments for Individuals #715, #273, #552, #414, #395, #753, #33, #228, #291, #92, #490, #211, #507, #37, #461, #423, #352, #699, #3, #273, and #296<br>**People Interviewed:**<br>1. Delia Schilder, RN, Chief Nurse Executive (CNE)<br>2. Sherri Courtney, RN, Nursing Operations Officer (NOO)<br>3. Sibylle Graviett, RN, RN Case Management Supervisor<br>4. Johanna Hayse, RN, Wound Care/Educator/Specialty Nurses' Supervisor<br>5. Maria Palenzuela, RN, Infection Control Preventionist (ICP)<br>6. Diane Porter, RN, Diabetic Nurse Educator<br>7. Linda Barnett, RN, Nurse Educator<br>8. Gwen Weiss, RN, Nurse Educator<br>9. Susan Hyde, RN, Nurse Manager, Cedar Falls<br>10. Sherrie Jones, RN, Nurse Manager, Houston Park<br>11. Hilda Clemente, RN, Nurse Manager, Eastfield<br>12. Traci Carroll, RN, Nurse Manager, Infirmary<br>13. Karin Denton, RN, RN Case Manager, Garden Ridge<br>14. Diane Klopp, RN, RN Case Manager, Garden Ridge<br>15. Mathew Mathew, RN, RN Case Manager, Cedar Falls<br>16. Valarie Kipfer, RN, MSN, State Office Nursing Coordinator<br>17. Linda Fischer, RN, Family Nurse Practitioner, State Office Consultant |

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| | 18. Staci Kraus, RN, Physical Nutritional Management Team (PNMT) Nurse<br>19. Deb Salsman, Director of Risk Management<br>20. Susan Harb, RM, Workers Compensation Case Manager<br>21. David Anderson, Safety Specialist<br>22. Allana Garrison, RN, Quality Assurance Nurse Supervisor/ Cardiopulmonary Resuscitation Instructor<br>23. Mary Harrison, RN, Quality Assurance Nurse (QA)<br>24. Lyndon Cotter, Unit Director, Cedar Falls<br>**Meeting Attended/Observations:**<br>1. Meeting with CNE, NOO, RN Case Manager, and Specialty Nurses, 10/8/12<br>2. Infirmary Morning Meeting, 10/9/12<br>3. Pharmacy and Therapeutics Committee Meeting, 10/9/12<br>4. Physical Nutritional Management Team Pre-Discharge Meeting for Individual #737, 10/9/12<br>5. Emergency Response Staff Interview, 10/10/12<br>6. Individual Support Plan (ISP) Meeting for Individual #250, 10/10/12<br>7. Medication Variance Committee Meeting, 10/10/12<br>8. Medication Administration Observations and Unit/Infirmary Tour at 4:00 p.m., 10/10/12<br>9. Physical Nutritional Management Committee Meeting, 10/11/12 |
| | **Facility Self-Assessment:**<br>The Facility's Self-Assessment, updated 9/24/12, provided comments/status for Section M, Provisions M.1 through M.6 of the Settlement Agreement. The Facility indicated it was not in compliance with Provisions M.1 through M.6. This was consistent with the Monitoring Team's findings as all Provisions were found to be noncompliant.<br><br>The new format used for the Facility Self-Assessment was much improved over the format used in previous reviews. This provided useful information for the activities they had engaged in for each Provision, as well as including the data they used to validate the activities, and provided a rationale for their self-assessment of compliance toward each Provision.<br><br>The Action Plan was equally as useful because it provided the Monitoring Team with a status of the action steps taken for each Provision stated which steps were completed and/or were ongoing, and the projected date of completion for action steps that were in progress. The action steps began to include self-initiated activities as opposed to only including activities related to the Monitoring Team's recommendations. The completion of these actions steps should lead the Facility forward toward reaching compliance with this Section of the Settlement Agreement. |
| | **Summary of Monitor's Assessment:**<br>Many positives were noted throughout the Provisions. DSSLC continued to take steps forward which would lead to compliance with all Provisions. Numerous improvements and new processes had been put in place since the last compliance review, such as: An Assessment of Assessments to ensure that Annual Nursing Assessments were completed within 10 days of individuals annual Individual Support Plan Meetings. The revised Integrated Risk Rating Forms and Integrated Health Care Plan processes were |

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| | implemented and all RN Case Managers were trained on the processes. Nursing Protocol Monitoring Tools were implemented and the Nurse Managers were beginning to use them. The comprehensive Nurse Manager Monitoring Tool had been developed and was in the process of implementation. The RNs and LVNs had received the Documentation Class taught by the State Office FNP Consultants. A new class for Medication Administration for Individuals with Dysphagia will be taught to Nursing Administrative/Management who oversee medication administration and to and direct care nurses who administer medications.<br><br>In addition to the Self-Assessment, the Facility had recently established four primary priorities related to meeting compliance with the Settlement Agreement. The Nursing Department's Nurse Managers, Diabetic Nurse Educator, Hospital Liaison Nurses, Nurse Educators, as well as the PNMT Nurse and QA Nurse, had identified activities for their respective responsibilities in meeting the Section M provisions. The priorities included: Protection from Harm related to Provisions M.1, M.2, M.3, M.4, M.5, and M.6; Assessments were Complete and Timely related to Provisions M.1, M.2, M.3, and M.4; Knowledge of Settlement Agreement and Intermediate Care Facility Standards; and Implementation related to Provisions M.3, M.5, and M.6. This was another promising self-initiated step forward in the Facility's efforts to meet compliance with Section M. The Monitoring Team will review the Facility's progress toward meeting these priorities at the next compliance review.<br><br>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.<br><br>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.<br><br>The Infection Control Preventionist had made significant improvements in the organizational structure and quality of the Infection Control Program. In an effort to reduce potential for cross infections for the medically complex individuals in Cedar Falls 512C, they were provided active treatment on their home units. This seems to make a difference in reducing the potential for infections. Coincidentally, this also reduced the incidences of medication variance because there was no rush to get individuals to the active treatment areas, by reducing the rush for nurses to administer mediations. The other specialty nurses continued to maintain the positive practices found at the last review and continued to work collaboratively with other disciplines to provide integrated services.<br><br>Since the last review 18 nursing protocols had been fully 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 Acute Illness and Injury Protocols. The Nurse Protocol Monitoring Tools were developed and implement by the Nurse Managers for all 18 Nursing Protocols. This should help the Nursing Department meet compliance with this provision. This section of the Provision needs continued improvements. |

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| | The Quality Assurance Department had hired a new QA Nurse who was conducting Medication Administration Observations and analyzing data. The QA Nurse was beginning to complete inter-rater reliability checks and was working with nursing staff that complete the monitoring tools to bring about greater degree of agreement on inter-rater reliability checks. The Medication Observation Tools were in the process of being revised to identify items that must be completed 100% of the time versus those of less significance. Some of the Nursing Care Monitoring Tools were discontinued because they were not providing useful data and were replaced by the Nursing Protocol Monitoring Tools.<br><br>The Facility's Emergency Response System met compliance with the requirements of the Emergency Response Policy, 044.<br><br>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 Section XI, overall nursing summaries need continued improvement to critically analyze clinical data for each identified nursing problem/diagnosis in order to accurately reflect whether individuals' health status was improving, maintaining, or regressing. Seventy two percent of RNs had completed the mandatory Physical Assessment and Documentation Class 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. Ninety two percent of the RNs and 82% of the LVNs had completed the new Documentation Class taught by the State Office FNP Consultant. The assessments and documentation of individuals' nursing care was beginning to show improvement in the quality and comprehensiveness of the nursing assessments, and documentation for individuals with acute changes in status related to specific affected body systems had continued to improve since the last compliance visit.<br><br>The Nursing Department had recently implemented and trained the RN Case Managers in the revised Integrated Risk Rating Form and Integrated Health Care Plan processes. The new process show promise in improving the Facility's ability to more accurately assess and identify individuals' level of risks for various conditions, then develop an integrated health care plan to address identified risk conditions. With the implementation of the revised Integrated Risk Rating Form and Integrated Health Care Plan processes, it is expected that these processes will move the Facility forward in meeting compliance with this Provision. The processes were so recently implemented that it was not yet possible to determine the effectiveness toward meeting compliance with these processes.<br><br>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. With the implementation of the revised Integrated Risk Rating Form and Integrated Health Care Plan processes, it is expected that these processes will move the Facility forward in meeting compliance with this Provision.<br><br>Provision M.4: This provision was determined not to be in compliance. The Nursing Education Department continued to have a well-organized infrastructure. The Nurse Educators continued to |

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| | 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. However, this Provision cannot meet compliance until all the Nursing Policies, Procedures, and Protocols are demonstrated through actual practice sufficient to meet the individuals' health care needs. The Nurse Educators continued to provide Clinical Indicators of Health Status Change Class at New Employee Orientation and as refresher training to incumbent staff.<br><br>Provision M.5: This provision was determined not be in compliance. Refer to Provisions M.2 and M.3 report above.<br><br>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 continuing to analyze data and determine how to represent it, as well as make it useful to improve medication practices.<br><br>A Nurse Educator, Diabetic Nurse Educator and the PNMT Nurse had received "train the trainer" Medication Administration for Individual's with Dysphagia. The training will begin in November 2012 for the Nursing Administrative/Management who oversee medication administration and direct care nurses who administer medications. The Facility continued to lack medication rooms where individuals could 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. | The Facility's Provision M.1 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, observations, and review of documents, showed there was 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.<br><br><u>Staffing</u><br>At the time of the compliance review, DSSLC had a census of 492 individuals. Since the last review, DSSLC had 130.50 positions allocated for Registered Nurses (RNs), and 88 positions for Licensed Vocational Nurses (LVNs), of which 107.50 RN positions were filled with 23 unfilled positions and 78 LVN positions filled with 10 unfilled positions. | Noncompliance |

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| | | Four of the RN positions were allocated to other departments. Despite the vacancies, primarily for direct care nurses, the Nursing Department had remained relatively stable. The Nursing Administration, Management, and Specialty 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.<br><br>The Nursing Department continued to monitor nursing staffing patterns and established nursing ratios for the Units and Infirmary daily on each shift. Staffing patterns and ratio data were analyzed and reported monthly, as well as overall for the last six months. The Monitoring Team's review of the nursing staffing patterns and ratio reports for the past six months found, as reported in the self-assessment, that the nursing ratios per shift/unit/Infirmary were occasionally not met. For the past six months, overall 35 of 67 (52%) shift shortages occurred on the 6-2 shifts. The CNE reported Nurse Managers and/or RN Case Managers were present to assist with covering staffing shortages on the 6-2 shift. The other shifts were reported to be staffed adequately and/or at ideal levels. However, the CNE did not report how the remaining 48% of staffing shortages were covered on the other two shifts, although they were reported to be adequately and/or at ideal levels.<br><br>Because of the nursing vacancies and/or in the case of nursing shortages, or when coverage was needed to cover while full time the nurses receive additional training, 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 RNs had slightly decreased and the hours for LVNs had slightly increased. The Facility RN overtime hours had slightly decreased and the LVN hours had slightly increased.<br><br>The Nursing Department continued to actively recruit nursing personnel. The CNE explained the Facility was located in an area that had numerous hospitals, which made it difficult to recruit and retain RNs because the hospitals only hired RNs coupled with paying higher wages than those of the Facility. The Nursing Department continued to conduct 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. In addition, they had continued efforts to enhance retention through a preceptor program, which assigned an experienced nurse to each new hired | |

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| | | nurse to reinforce learning during their orientation period. Refer to Provision M.4 for retention efforts made through the use of a preceptor program.<br><br><u>Quality Assurance Efforts</u><br>The Monitoring Team reviewed the Section M Nursing Care Monitoring data reported for the first through the fourth quarter in the QI/QA Council Meeting Data Analysis Reports on 8/24/12 and 9/18/12. The data reviewed was consistent with the data reported in the Facility's Self-Assessment.<br><br>At the last compliance review the threshold for percentage of overall compliance with each monitoring tool had been changed from 80% to 85%. The monitoring tool overall percentage of compliance was averaged quarterly. The overall second, third and fourth quarter data for the Nursing Care Documentation Monitoring Tool showed that the overall percentage of compliance fell below 85%, respectively 84.6%, 84.2% and 83.2%. The overall first and second quarter data for the Nursing Care Urgent/Emergency Room Visit and Hospitalizations Monitoring Tool showed that the overall percentage of compliance fell below 85%, respectively 74.8% and 84.1%. There were no systemic corrective action plans (CAPs) available for these overall compliance scores below 85% compliance. Reportedly, for items within each tool falling below 85% compliance, corrective actions were addressed at the Unit level by the respective Nurse Managers. There was no documentation available to verify whether corrective action was taken by the Unit Nurse Managers for items within each tool that might have fallen below 85%.<br><br>The overall monthly average inter-rater percentage of agreement between the nursing staff and the QA Nurse across all monitoring tools showed: April – 72%; May – 72%; June - 81%; July – 65%; and August – 79%. These figures indicate a need to re-define items on the tools, retrain monitors, or otherwise improve inter-rater agreement.<br><br>The process for completing the Nursing Monitoring Tools was revised on 10/4/12. The revised process included the following changes:<br>• Twelve RN Case Managers were assigned to complete 10 monitoring tools each month.<br>• The random sample of tools to be audited was assigned by the Quality Assurance Department's Data Analyst.<br>• A group of RN IVs were each assigned to complete three to four Urgent Care/Emergency Room/Hospitalizations Monitoring Tools.<br>• The Medication Administration and Documentation Monitoring Tools were assigned to the new QA Nurse for completion and to review and analyze the results during the Medication Variance Committee Meetings. The QA Nurse was in the process of setting up a monitoring schedule. The QA Nurse will also conduct inter-rater | |

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| | | training with the Unit Nurse Managers.<br>• Effective 11/1/12, the following monitoring tools will be discontinued due to additional process changes: Prevention, Management of Respiratory Distress, Seizure Management, and Documentation.<br>• The Nurse Managers began using the new Protocol Card Audit Tools. A formal process for assignment and completion will be developed by the Nursing Department in collaboration with the Quality Assurance Department.<br>• Timelines were established for the monitoring process.<br>• The Section Leaders met 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.<br><br>The CNE stated the above Nursing Care Monitoring Tools were being discontinued because they did not provide meaningful data and were being replaced by more appropriate Protocol Card Audit Tools. The Protocol Card Audit Tools were recently developed for all 18 Protocol Cards by the State Nurses Workgroup. The Nursing Department began using the audit tools in October 2012. Therefore, no data from these audits were available for review. In addition the State Nurses Workgroup was in the process of identifying essential items on the monitoring tools that must consistently meet 100% compliance. Failure to meet 100% compliance will require corrective action locally and/or systemically. The Monitoring Team will review the results of the Protocol Card Audit Tools at the next compliance visit.<br><br>It was positive to find that since the last review, as recommended by the Monitoring Team, the Nursing Department had developed and recently implemented additional Nursing Care Monitoring Tools to improve nursing practices and to further move forward in meeting compliance with the Settlement Agreement. The additional monitoring tools, nursing staff assigned to conduct the monitoring, and the frequency for monitoring are listed below:<br>Nurse Managers:<br>• Complete four Medication Administration Observations per month on assigned nurses.<br>• Complete four Universal Monitoring Tools per month on assigned nurses.<br>• Complete Protocol Documentation Audits.<br>• Complete two Nurse Manager Monitoring Tools per month.<br>RN Case Managers:<br>• Complete four Universal Monitoring Tools per month on assigned individuals.<br>o Meal Monitoring as identified by Unit needs. | |

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| | | o Monitor Aspiration Trigger Plan (ATP) flow sheets for individuals on their caseload, weekly.<br>o Monitor Individualized Aspiration Trigger Data Sheets weekly on identified individuals.<br>o Monitor Care Plans: Minimally weekly for Acute Care Plans or as identified on Health Care Protocols and/or Risk Action Plans.<br>• QA Nurse:<br>o Complete Medication Administration Observations on assigned nurses.<br>o Complete four Pharmacy Monitoring Tools per month.<br>o Complete four Universal Monitoring Tools per month.<br>• Infection Control Preventionist Nurse:<br>o Complete Handwashing Monitoring Tools monthly.<br>o Environmental Survey Monitoring Tools Monthly.<br>Since most of these monitoring tools and processes were recently implemented or revised, there were no aggregated and analyzed data available for review, with the exception of the Medication Administration Observation data, which is reported in Provision M.6. However, examples of completed Nurse Manager Monitoring Tools for two Units for August 2012 and September 2012 were provided for review. The tools contained comprehensive items related to each Provision for Section M. There was documentation on the tools that corrective action was taken by the Nurse Managers for items found deficient. At the next compliance visit the Monitoring Team will look for aggregated and analyzed data, as well as evidence of corrective action taken on the above monitoring tools.<br><br>In addition to maintaining the positive practices identified in the report, to meet compliance with the section's requirement of the Provision, the Nursing Department should consider making the following improvements:<br>• Ensure that all nursing auditors rating the monitoring tools are clinically competent and that there is consistency between auditors, as well as between the nursing staff and the QA Nurse performing inter-rater checks.<br>• Collaborate with the Quality Assurance Department to develop a formal method for conducting inter-rater checks and to measure the effectiveness of the process.<br>• 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.<br><br><u>Assessment and Documentation of Individuals with Acute Changes in Status</u><br>Since the last compliance review, it was positive to find the Infirmary Morning Meetings had continued to become more integrated. The Infirmary Charge Nurse Chaired the meetings and provided a report on individuals receiving care in the Infirmary, as well as | |

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| | | a report from the 24 Hour Shift Report regarding individuals residing in the Units. The Hospital Liaison Nurses provided a report on individuals who were in the hospital and their projected discharge dates. The on-call physician provided a report of calls received overnight and/or over weekends and holidays. Once a week there was a full integrated meeting that included representatives from all clinical disciplines. The need for referrals and follow-up were discussed regarding individuals identified with a change in status. This was validated by the attendance of the Monitoring Team at the meeting on 10/9/12. In addition to attendance of medical staff and representatives from administration and IDTs; the nursing staff included: Hospital Liaison Nurses, Diabetic Nurse Educator, Wound Care Nurse, Infection Control Nurse, PNMT Nurse, and RN Case Manager Supervisor. The RN Case Managers did not attend the meeting because they routinely attend their respective Units' Incident Management review Team Meetings (IMRTs). The RN Case Manager Supervisor reported any pertinent information after the meetings to them. Sign-in sheet for staff were not kept, therefore it was not possible to specifically identify which other discipline attended beyond the nursing and medical staff. The reports and discussions focused primarily on individual specific health status and care. There were no systemic issues identified. The Hospital Liaison Nurse reported Individual #211 had developed skin integrity issues on his back and buttocks. It was positive to find his skin integrity issues were referred to the Wound Care Nurse to go to the hospital to assess the skin integrity issues.<br><br>As a follow-up to the morning meeting, the Wound Care Nurse went to the hospital immediately after the meeting and assessed and reported back to the Hospital Liaison Nurse and the IDT the status of Individual #211's skin integrity issues and recommendation for treatment. A copy of the Wound Care Nurse's Integrated Progress Notes was provided to the Monitoring Team. Several redden and blanchable areas were found on the buttocks, middle of the back near thoracic spine, and left elbow. None of the areas had skin breakdown or showed evidence of infection. Wound care instructions were provided to the staff to manage the skin integrity issue and to prevent skin breakdown.<br><br>It was positive to find that new and larger space had been remodeled to provide clinical services, which included a waiting room with a television set and other amenities for individuals. This simulated a "real medical waiting room", which should make the individuals feel more comfortable while they wait for their appointments. Individuals were brought in at the back of the clinic to the waiting room, which prevented congestion around the clinic rooms where individuals were being examined. This was a significant improvement from the previous clinic area which was a small crowded space for clinicians to work, without a waiting room for individuals to wait comfortably.<br><br>The Monitoring Team's review of unified records for Individuals #715, #273, #552, | |

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| | | #414, #395, #753, #33, #228, #291, #92, #490, #211, #507, #37, #461, #423, #352, #699, #3, #273, and # 296, selected across Units/Infirmary, who were rated at high and/or medium risk for a variety of health conditions, identified the following trends: The quality and comprehensiveness of the nursing assessments and documentation for individuals with acute changes in status related to specific affected body systems had continued to improve since the last compliance visit. The improvements may be attributable to several action steps taken, which included: Documentation Classes taught to the RNs and LVNs by the State Office FNP Consultant and implementation of 18 nursing protocols with increased monitoring by the Unit/Infirmary Nurse Managers.<br><br>The Self-Assessment reported: The lowest overall average for the Acute Illness and Injury Monitoring Tool was 87.6% in the first quarter. The highest overall average for the Acute Illness and Injury Monitoring Tool was 91.4% in the fourth quarter with an overall compliance average of 89.6%. For the Documentation Monitoring Tool the lowest overall average was 84.6% in third quarter ranging to the highest overall compliance average of 96.5% in first quarter with and overall compliance average of about 87.9%. The lowest overall average for the Urgent Care Monitoring Tool was 74.8% in the first quarter ranging to the highest overall average of 93.1% in the fourth quarter with an overall compliance average of 85.3%. This was consistent with the Monitoring Teams' findings.<br><br><u>Areas that showed continued improvement:</u><br>• There was consistent use of the SOAP format for documentation.<br>• The nursing staff more consistently notified the medical providers promptly when there were significant acute changes in individuals' physical and/or mental health status.<br>• The 18 nursing protocols were more consistently followed.<br>• Individuals placed on 24 and/or 48 hour Nurse Watch Monitoring were more consistently followed through to resolution.<br>• The follow-up documentation of assessments on individuals with acute change in status more consistently stated what would be followed up, but did not consistently state the frequency of the follow-up activities.<br>• Individuals' response per necessary (PRN) medications were more consistently documented on the back of the Medication Administration Record (MAR) and/or in the Integrated Progress Notes. However, the effectiveness of the PRN medications was rarely documented.<br>• Individuals' level of comfort or discomfort and mental status were more consistently included in the assessments completed related to the illnesses or injuries.<br>• The Pre and Post Hospital and Emergency Room Visit Records were more consistently completed according to the Nursing Protocol: Hospitalizations, | |

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| | | Transfers, and Discharges. The was validated through review of hospital admissions of Individuals #699 on 8/8/12; #211 on 8/16/12 and 8/26/12; and #352 on 8/21/12.<br>• Documentation in the Integrated Progress Notes was beginning to show more collaboration/integration with other disciplines.<br><br><u>Areas that need continued improvement:</u><br>• The resolution notes for nursing care provided to individuals with acute changes in status issues were not consistently documented when their problems were resolved or the effectiveness of the treatments/interventions provided. The therapeutic response to antibiotic therapies regarding side effects/adverse drug reactions, and the effectiveness of the medications were not consistently documented.<br>• When errors were made in documentation they were not consistently corrected properly with a straight line drawn through the entry, dated, and initialed.<br>• There was a lack of documentation in the Integrated Progress Notes when Health Management and Acute Care Plans were initiated and whether the direct support professionals were trained on the plans.<br>• Injuries related to individuals maladaptive behaviors were rarely documented as reported to the behavioral staff.<br>• When individuals were sent to the emergency room and/or hospital, the "nurse to nurse" communication was not consistently documented in the Integrated Progress Notes. Skin assessments were documented 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. For individuals admitted to the hospital the Hospital Liaison Nurses completed skin assessment and reported any problems to the Wound Care Nurse and other relevant IDT staff. Notifications to the Facility administration, IDT, and/or family/guardian were not consistently documented, particularly for emergency room visits.<br>• The method temperatures were taken was not consistently documented. 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. Oxygen saturations did not consistently indicate whether they were measured on room air or oxygen.<br>• The legibility of the nurses' handwriting had not significantly improved since the last review.<br>• The nursing entries were not consistently timed.<br>• Military time was not consistently used.<br><br>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 and documentation to ensure they are consistently followed.<br><br>The Monitoring Team's review of the past three months of 21 individuals' Daily Active Treatment Specialist Records and Flow Records for Active Treatment Programs (ATPs) found that neither of the records were completed consistently daily and on each shift by the direct care professionals. It is essential that these records are completed daily on each shift to ensure that individuals' receive their prescribed treatments, and are monitored, particularly, for dining (meals and snacks) and bowel elimination. The Nursing Department should collaborate with other relevant disciplines to ensure that Daily Active Treatment Specialist Records and Flow Records for Active Treatment Programs (ATPs) records are completed daily on each shift.<br><br><u>Hospital Liaison Nurses' Activities</u><br>The Monitoring Team interviewed the Hospital Liaison Nurses, and listened to their reports at the Morning Infirmary Meeting on 10/9/12 for individuals hospitalized. As was found at the last compliance review, the Hospital Liaison Nurses continued to perform the following activities: They made daily hospital rounds (Monday through Friday). 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 reviewed systems; new physician orders; results of lab and diagnostic tests; and discharge planning for estimated date of discharge, and medical/health needs after discharge; interviewed nurses and physicians providing care to hospitalized individuals. After visits to the hospital, the Hospital Liaison Nurses reported and scanned all medical information 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.<br><br>The Hospital Liaison Nurses routinely attended Infirmary Morning Meetings 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 | |

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| | | individuals' health status that would require revising their risk ratings and risk action plans. These activities have resulted in a more integrated approach for care of the individuals served. The Hospital Liaison Nurses should also review the Integrated Progress Notes and associated documentation forms for individuals admitted and discharged from the hospital and/or emergency room to ensure compliance with the Nursing Protocol: Hospitalization, Transfers, and Discharges, June 2011.<br><br>The Monitoring Team validated the above activities through review of the Hospital Liaison Reports, Integrated Progress Notes, and other related medical records for Individuals #414, #673, #42, #220, #30, #211, and #737. Further validation of the Hospital Liaison Nurses' activities was demonstrated through the Monitoring Team's attendance at the PNMT's Pre-Discharge Planning Meeting for Individual #737 who was diagnosed and treated for a fractured hip. The Hospital Liaison Nurse attended and actively participated in providing the team with pertinent information regarding Individuals #737's health status and needs for post-discharge. This was one of the most positive and productive team meetings attended by the Monitoring Team because it resulted in a broadening of the discussion that identified risks levels beyond Individual #737's primary problem of a fractured hip. The results of the PNMT Pre-Discharge Meeting were sent to the IDT for final disposition.<br><br>The CNE reported other positive improvements had been made in individuals' care in the area hospitals during their hospital stay and after discharge. The Facility was able to work with Denton Regional Medical Center Hospital and Care gate (formally Presbyterian of Denton) Hospital to obtain credentials for the Hospital Liaison Nurses. Prior to the credentialing, the Hospital Liaison Nurses were only able to visit individuals as a guest, which limited their ability to assess individuals and obtain access to their medical records. Now they were able to have full access to individuals' hospital records, communicate directly with individuals' primary and charge nurse, as well as discuss individuals' diagnoses and concerns with the admitting physicians and any consult physicians. Remote and in-hospital access to records was available for the Hospital Liaison Nurses to review, print and share with the IDT. This had positivity impacted the overall care of individuals by having and sharing accurate and timely health information with the primary care providers and IDTs. By having accurate and up to date information available prior to the individuals' discharge, the IDTs were able to meet prior to the individuals' discharge to identify and put any new supports and services in place prior to their discharge. This also allowed a more collaborative approach between the hospital physicians and the Facility physicians. In addition, fewer errors in medications and diets were made because of the Hospital Liaison Nurses' ability to review all orders and to collaborate with the hospital staff to ensure individuals' home medications, treatments, positioning schedules, and diets were accurately followed while hospitalized. | |

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| | | Diabetic Nurse Educator Activities<br>The Diabetic Educator Nurse continued the same activities identified and reported in the last compliance review, as well as continued to make improvements in the Diabetic Management Services. In addition to the activities identified in the last review, the Diabetic Educator Nurse performed the following new activities:<br>• In order to promote interdisciplinary/integrated efforts, a Diabetic Management Team was organized and formed, which consisted of physicians, clinical pharmacist, dietician, diabetic nurse educator, and nurses. The team's initial projects focused on the prevention and effective management of diabetes through healthy food choices. Anticipating the challenges that face individuals with holiday food choices, the team's next project was to make recommendations to assist in promoting compliance with healthy eating, not only for individuals with diabetes , but for all individuals who reside at the Facility.<br>• The Diabetic Nurse Educator was now an active participant at IDT meetings for 49 individuals diagnosed with diabetes. She assists IDTs with planning, implementation, and evaluation of care for individuals with diabetes across campus.<br>• Guidelines for a Nursing Management of Diabetes Protocol had been drafted and were awaiting approval by the Facility. This was a positive finding, and when approved and implemented should serve to ensure continuity in diabetic management.<br>• The Diabetic Nurse Educator was working collaboratively with the IDTs and Pharmacist to identify early, individuals who may be at risk for metabolic syndrome. Weights and waist circumferences were measured. The final results were not yet available. The Monitoring Team will review the results of the risk assessments for metabolic syndrome at the next compliance review.<br>• Glucometer control checks were completed weekly, using two levels of control solutions across campus to ensure quality glucose monitoring. The primary or charge nurses were responsible for the completion of the quality control checks. Nurse Managers verified the completion of the weekly glucometer control checks. The Diabetic Nurse Educator provided oversight while making rounds on the homes. The Monitoring Teams verified that glucometer control checks were completed as described through review of the Units', Infirmary, and individuals' Glucometer Monitoring Records for August 2012 and September 2012. The review found 100% of the glucometer controls were checked weekly and the type one and two control testing solutions were in date. This was a significant improvement in compliance with checking glucometer controls from previous reviews.<br><br>The Monitoring Team interviewed the Diabetic Nurse Educator and RN Case Manager and reviewed diabetic trend data as well as records and related documents for | |

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| | | Individuals #367, #401, #210, #611, #526, #411, and #492. The review demonstrated and validated several of the activities described above in the Diabetic data reports and showed improvement in individuals' diabetic control, which was most likely due to the increased integration of diabetic management by the Diabetic Nurse Educator in collaboration with individuals' IDTs. Stat doses of hypoglycemic medication reported by the Pharmacy were reviewed and cross-referenced to document incidents of individuals' incidents hypoglycemia for accuracy and follow-up. The review found:<br>• Individual #367's (whose diabetes was managed by insulin and dietary management) data for hypoglycemia and hyperglycemia from May 2012 through September 2012 showed a progressive decrease in the monthly incidences of both hypoglycemia and hyperglycemia episodes. The Monitoring Team reviewed Individual #367's Health Management Plan (HMP) with the Diabetic Nurse Educator and his RN Case Manager. The HMP was generic and was not individualized to reflect the diabetic interventions provided. The need to revise his plan to actually reflect his diabetic management was discussed with the Diabetic Nurse Educator and RN Case Manager.<br>• Individual #401 whose diabetes was managed by insulin and dietary management data for hypoglycemia and hyperglycemia from May 2012 through September 2012 showed a progressive decrease in the monthly incidences of both hypoglycemia and hyperglycemia episodes.<br>• It was reported by the Diabetic Nurse Educator that after Individuals #210, #611, #526, #411, and #496 with type II Diabetes had their cross-reference of metformin dosages, current HgbA1c, and blood glucose trend data for 2012 reviewed by the respective physician these Individuals' had their medication dosages either decreased or discontinue due to weight loss, glycemic control, and normalization of blood glucose trending.<br><br>The Diabetic Nurse Educator should review diabetic health care plans to ensure they are current and reflect the actual interventions carried out specific to the individuals.<br><br><u>Wound Care Nurse Activities</u><br>As was found at the last review, the Wound Care Nurse continued to maintain the positive practices identified by consistently following, tracking, and reporting skin integrity issues and decubitus ulcers and keeping the IDTs informed of individuals' skin integrity issues. The Wound Care Nurse reported skin integrity issues/decubitus ulcers at the quarterly Physical Nutritional Management Committee (PNMC) meetings. The Monitoring Team attended the PNMP Committee quarterly meeting on 10/11/12 where the Wound Care Nurse presented a summary of skin integrity issues for June 2012 through September 2012. The summary described the following incidents of skin integrity issues/decubitus ulcers, including interventions, and systemic recommendation | |

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| | | to reduce the incidents:<br>• Five were Hospital Acquired:<br>o 1 Stage II<br>o 3 Stage III<br>o 0 Stage IV<br>▪ 4 were newly acquired decubiti<br>▪ One reopened previously resolved decubitus<br>o 1 Suspected Deep Tissue Injury (STDI)<br>• Nine were Facility Acquired:<br>o 7 Stage II<br>o 2 Stage III<br>▪ 6 were newly acquired decubiti<br>▪ 3 reopened previously resolved decubiti<br>The Wound Care Nurse recommendations stated that there did not seem to be a pattern in the decubitus issues described above. She further stated they will continue to initiate various efforts to address and decrease the incidents of decubiti. However, these systemic efforts were neither described nor discussed in by committee. Although for a Facility of this size, with many individuals determined to be medically complex/fragile, the risk of developing skin breakdowns and decubiti remains high. In most cases, decubitus ulcers results from inadequate support by direct care, and can be exacerbated by poor nutrition, dehydration, and underlying medical conditions. The Wound Care Nurse should review skin integrity/decubitus health care plans to ensure they are current and reflect the actual interventions carried out specific to the individuals. The Facility should enhance its direct care support to prevent decubitus ulcers from developing, and ensure that all individuals who sustain a recurrent lesion, or any decubitus ulcer of stage II or greater, be evaluated by the Facility clinician. Refer to Provision M.3 regarding Acute Care Plans and management of skin integrity issues and management of infections.<br><br>As was found in previous reviews, a review of the email provided by the Wound Care Nurse, included communication with relevant nurses and other IDT members regarding whether assessments, interventions, treatments, and instructions for care were being carried out. However, all of the pertinent communication was not consistently found documented in the Integrated Progress Notes. The use of e-mail communication was discussed with the CNE, NOO, and the Wound Care Nurse. They agreed that e-mail communication was a quick and easy method of communication to use and agreed pertinent communication should be documented in the Integrated Progress Notes. The Monitoring Team will follow-up on this issue at the next compliance review.<br><br><u>Infection Control Preventionist Activities</u><br>Since the last review, the Infection Preventionist had continued to maintain the positive | |

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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:
<ul>
<li>The Infection Control Preventionist chaired the quarterly Infection Control Committee meetings. The Committee continued to take 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.</li>
<li>The Monitoring Team reviewed the Quarterly Infection Control Committee minutes for 4/20/12 and 9/28/12, which validated the participation of the interdisciplinary staff. In addition to reporting Monthly Communicable Disease data to the Infection Control Committee, the data were provided to the IMRT, Unit Directors, Unit Managers, Building Coordinators, Nurse Managers, RN Case Managers, and other relevant staff when indicated. The Infection Control Preventionist Nurse continued to track infections by type and perform an excellent trend analysis by, home, Unit, and campus-wide. Corrective actions were implemented with follow-up action to evaluate the effectiveness of the corrective action for each type of infection reported by home, Unit, and campus-wide; as well as for other infection control data. This information was presented at the committee meetings for discussion and disposition of identified infection control issues.</li>
</ul>
The Monitoring Teams' review of the Incidence of Infection data for 2012's first, second and third quarter reports found data were tracked, analyzed, and trended by infection types, percentage, and rates. Rates were calculated using a standardized formula, the number of infections, by type, divided by census times the number of days, times 1000 (for 1000 patient bed days.). In addition, the reports included narrative analyses of the incident of infections by home, Unit, and campus-wide, along with corrective action plans for each type of infection, and a follow-up response. The results of the quarterly reports are listed in the chart below:
<table>
<tr><td></td><td>First Quarter</td><td>Second Quarter</td><td>Third Quarter</td></tr>
<tr><td>Type of Infection</td><td>Respiratory</td><td>Respiratory</td><td>Respiratory</td></tr>
<tr><td>Number of infections</td><td>96</td><td>69</td><td>44</td></tr>
<tr><td>Rate of Infections</td><td>2.11</td><td>1.52</td><td>0.97</td></tr>
<tr><td>Type of Infection</td><td>Conjunctivitis</td><td>Conjunctivitis</td><td>Conjunctivitis</td></tr>
<tr><td>Number of infections</td><td>50</td><td>36</td><td>31</td></tr>
<tr><td>Rate of Infections</td><td>1.10</td><td>0.79</td><td>0.68</td></tr>
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| Type of Infection | Aspiration Pneumonia | Aspiration Pneumonia | Aspiration Pneumonia |
|---|---|---|---|
| Number of infections | 14 | 3 | 5 |
| Rate of Infections | 0.31 | 0.07 | 0.11 |
| Type of Infection | Other Pneumonia | Other Pneumonia | Other Pneumonia |
| Number of infections | 26 | 20 | 17 |
| Rate of Infections | 0.57 | 0.44 | 0.37 |
| Type of Infection | Pseudomonas | Pseudomonas | Pseudomonas |
| Number of infections | 3 | 1 | 1 |
| Rate of Infections | 0.07 | 0.02 | 0.02 |
| Type of Infection | Urinary Tract Infections | Urinary Tract Infections | Urinary Tract Infections |
| Number of infections | 56 | 57 | 59 |
| Rate of Infections | 1.23 | 1.25 | 1.30 |
| Type of Infection | Skin and Soft Tissue Injury | Skin and Soft Tissue Injury | Skin and Soft Tissue Injury |
| Number of infections | 93 | 113 | 100 |
| Rate of Infections | 2.05 | 2.48 | 2.20 |
| Type of Infection | C-Diff | C-Diff | C-Diff |
| Number of infections | 3 | 2 | 2 |
| Rate of Infections | 0.07 | 0.04 | 0.04 |
| Type of Infection | VRE | VRE | VRE |
| Number of infections | 1 | 0 | 1 |
| Rate of Infections | 0.02 | 0.00 | 0.02 |
| Type of Infection | MRSA | MRSA | MRSA |
| Number of infections | 12 | 7 | 3 |
| Rate of Infections | 0.26 | 0.015 | 0.07 |

In order for the Monitoring Team to validate that significant improvements were found in reducing the incidences of infections it was necessary to include in this report the Infection Control Preventionist Nurse's narrative analyses of data from January 2012 through September 2012, as well as corrective actions taken to prevent and/or reduce the incidence of infections.

- Respiratory Infections and Pneumonia: According to the Infection Control Preventionist Nurse's narrative analysis, there was a significant reduction in the incidence of respiratory infections for the last two quarters.
    - The majority of individuals diagnosed with upper respiratory infections were diagnosed with sinusitis, bronchitis, rhinitis, pharyngitis, and other

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| | | like infections. In January through May 2012 the majority of incidences were in Cedar Falls. In June 2012, Eastfield had the highest incidence in 504 A and C, 505 A and C homes.<br>o The incidence of aspiration pneumonias and other pneumonias also trended down compared from last year and the first quarter of this year. The incidence of aspiration pneumonias occurred throughout the campus, but predominately in 503's, 507's, 512C, 515B, 522C, and 522D homes. The majority of other pneumonia incidences occurred in Cedar Falls for which there were 31 cases and the next highest incidences occurred in Westridge where there were 10 cases reported. Although there continued to be incidence of aspiration pneumonia infections there was documentation that the Facility had identified risk factors related to aspiration pneumonia, such as identification of individuals with decreased or absent gag reflex, dental problems, dysphagia, individuals on enteral feeding, and seizure disorders. The corrective actions and interventions were based on prevention and control of identified risk factors. The Facility had formed an Aspiration Pneumonia/Pneumonia Workgroup as part of the PNM Committee, which meets every Thursday to discuss current problems identified related to the prevention of aspiration pneumonia. Refer to Section O for more information related to aspiration pneumonia.<br>• Conjunctivitis: There was a significant decrease in the number of conjunctivitis infections since May 2012. The majority of infections were in Cedar Falls 502's, 503's, and 512's homes. The primary care providers were given in-service training by the contract Infection Control Physician on the different types of conjunctivitis. Because of the additional training, it was reported that the primary care providers were better able to distinguish their diagnoses of conjunctivitis as to whether they were bacterial, viral, or allergy.<br>• Pseudomonas: The Facility had low incidences of pseudomonas infections (five). The majority of which were in Cedar Falls 502D, 503B, 512C homes, and one in Huston Park. The highest incidence of pseudomonas was cultured in urine and sputum, including an individual on 512C, who had a repeated positive culture for this organism within six months that could be a possible colonization. Although the incidence of pseudomonas infections was low, the Facility recognized the serious and potentially life threatening ramification of this organism and had worked to treat and eradicate. In addition to implementing corrective action for standard infection control measures, particularly in 512C, the Facility had undertaken stringent environmental cleaning measures that included installing air scrubbers to destroy microbials in the air and on surfaces, maintenance staff changed air filters twice a month, housekeeping added extra housekeepers to provide more extensive environmental cleaning and disinfecting, direct support professionals (DSPs) were provided specific training on the transmission of pseudomonas, and DSPs were | |

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| | | instructed to ensure that all bathing tables were cleaned and disinfected after each individual use.<br>• Two Adenosine Triphosphate (ATP) Luminometer devices for monitoring environmental cleaning were installed. The ATP Luminometer device measures Adenosine Triphosphate, the universal energy molecule found in all animal, plant, bacterial, yeast, and mold cells. The ATP testing shows how clean surfaces are by detecting the level of microbial contamination of surfaces in sections. The Infection Control Preventionist Nurse and selected QA staff were trained on the ATP Luminometer device use and data collection. Since the devices were just recently put into use, no data was yet available to measure its effectiveness. The Monitoring Team will review the data at the next compliance visit for effectiveness in improving environmental cleaning.<br>• The Monitoring Team attended the PNM Committee meeting on 10/11/12 where the Facility continued to investigate disinfectant products that could be safely used that would kill the pseudomonas organisms as well as their spores. No firm decision was made on the disinfectant products and this would continue to be explored by the Infection Control Preventionist Nurse.<br>• Skin and Soft Tissue Infections (SSTI): SSTIs accounted for the overall highest incidence of infections reported. The majority of the individuals were diagnosed and treated for recent injuries to the skin, wound abrasions, presence of fungal infections, abscesses, furuncles "boils", carbuncles, cellulitis, and other like infections.<br>• Urinary Tract Infections (UTIs): UTIs were the second highest incidence of infections reported. The majority of the UTIs were in Cedar Falls 502's, 503's, and 512's homes.<br>• Multi-drug resistant organisms (MDROs): The Facility continued to have a low incidence of MDRO infections. Methicillin-resistant Staphylococcus aureus (MRSA) infections showed a significant decrease over the past three quarters. The majority of these infections were in Cedar Falls, which had nine cases reported. There was a very low incidence of Vancomycin-resistant Enterococcus (VRE). The infections occurred in Cedar Falls and Houston Park, which had one case each reported. There was a low incidence of Clostridium Difficile (C-Diff) infections. The majority of the infections were in Cedar Falls in the 503's homes, which had two cases reported.<br><br>For each of the reported infections there was documentation that appropriate corrective action was taken to enhance infection control measures to prevent and/or reduce the incidence of infections. It was plausible that the decreased incidence of most of the infections was due to thorough investigation by the Infection Control Preventionist Nurse and other direct care providers to identify underlying and causative factors contributing to the infections and the enhanced infection control | |

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| | | measures implemented and effectiveness evaluated to prevent cross contamination and risk of infections.<br>• There were no reports of infectious trends for employees.<br>• The Facility continued to contract with an Infectious Disease Doctor who provided consultation services on individuals' infections and education to clinical staff.<br>• The Infection Control Preventionist Nurse developed and published a monthly "Hands on Infection Control" Infection Prevention and Control Newsletter. The purpose of the newsletter was to provide all DSSLC staff with information and updates on contemporary infection control and prevention and control issues relevant to the workplace.<br>• The Infection Control Preventionist Nurse continued to prepare monthly antibiogram/epidemiology reports that provided data to the primary care providers on appropriate usage of antimicrobial agents. The data were also reported at the Pharmacy and Therapeutic Committee meetings and reflected in the minutes.<br>• There was documented evidence that Infection Control Preventionist continued to:<br>o Provide training on Infection Control Measures, including Hand Hygiene and Standard Precautions, at New Employee Orientation and at annual re refresher training. The training included practical hand washing demonstrations by the staff using ultra-violet light to show areas on the hands that were not properly washed.<br>o Conduct Handwashing and Standard Precaution Surveillance in the homes at least once a week. The Monthly Handwashing Compliance Report validated that Infection Control Preventionist Nurse observed handwashing on at least 35 new employees monthly on proper handwashing techniques, with corrective action taken when deficiencies were found. She also completed spontaneous handwashing surveillance once a week while making home surveillance rounds. All audit findings were shared at the quarterly Infection Control Committee meetings, as well as at other relevant interdisciplinary team meetings, e.g., Incident Management Report Team, Environmental Team, and Residential Services. The audits continued to find some female employees 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.<br>o Conduct unannounced monthly Environmental Surveillance of Homes/Units/Kitchens. The deficiencies found, data collected, actions taken, and follow-up information were recorded in Surveillance Reports and provided to Building Coordinators, Unit Managers, and at the Infection Control Committee Meetings.<br>o Maintain an immunization database for individuals and employees. | |

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| | | Individuals and employees found delinquent with immunizations can be readily identified and brought up to data.<br>▪ For 2012 there was a 100% compliance rate for individuals receiving annual tuberculosis (TB) skin testing. There was one TB converted individual who had a chest x-ray that was negative.<br>▪ For 2012 there was a 100% compliance rate for employees receiving annual TB skin testing. There were nine TB converted employees who had negative chest x-rays and TB questionnaires completed.<br>▪ As of 3/8/12, 736 (52%) employees had received the complete series of Hepatitis B vaccinations. At least 126 employees were found to have received the first and second doses but did not return for the third dose, even with reminder letters sent to them. On 9/15/12, at least 991 (60%) employees had been vaccinated for Hepatitis B. The Infection Control Preventionist and Clinic Nurse continued to offer the Hepatitis B vaccinations during New Employee Orientation, especially new employees who were at risk (physicians, nurses, DSPs, respiratory staff, and other who provide direct care).<br>▪ The 2012 seasonal influenza vaccinations were in process for individuals and employees; therefore, no data was yet available. There was evidence that notification and schedules for seasonal influenza vaccines had been sent to the nursing staff and employees. The Monitoring Team will review the 2012 seasonal influenza data at the next compliance review.<br>• According to CTD's Course Delinquency/Due List, 9/18/12, 12 employees were one to two months delinquent in annual refresher Infection Control Training. This was an improvement since the last compliance review where 16 employees reported delinquent for several months. It is essential that all employees remain current in their annual refresher Infection Control Training.<br><br>The method used by the Infection Control Nurse for real-time infections reports included daily: Attendance at the Infirmary Morning Meetings, review of Pharmacy Antibiotic Reports, 24 Hour Nursing Shift Logs, and lab reports for cultures and sensitivities. As was found in past reviews, the Nursing Department did not have a formalized reporting process that directly sent daily notification of infections to the Infection Control Preventionist. In order to ensure the Infection Control Preventionist Nurse has real-time reports of infections, the Nursing Department should ensure that the nursing staff notifies her when infections are diagnosed and treated. The Infection Control Preventionist Nurse should review all infection health care plans to ensure they include the Antibiotic Therapy Protocol requirements and reflect the actual interventions carried | |

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| | | out specific to the individuals. Refer to Provision M.3 regarding Acute Care Plans and management of infections.<br><br><u>Availability of Pertinent Medical Records</u><br>Records were made available onsite without difficulty or delay. As was found in past reviews, numerous emails were provided to demonstrate integrated communication with other disciplines. The emails contained pertinent 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. This was discussed with the CNE and Nursing Management/Specialty Nurses who agreed to ensure that all pertinent information communicated via e-mail was also documented in individuals' active records. The Monitoring Team will follow-up on this issue at the next compliance review. Errors in documentation in the records were not consistently corrected properly. The legibility of handwriting and signatures continued to be difficult to read in some of the documentation reviewed. Occasionally individuals' demographic information was not on the records. Occasionally the time of the entries were not documented in the Integrated Progress Notes.<br><br><u>Mock Medical Emergency Drills and Emergency Response Activities</u><br>Since the last compliance review, the Facility continued to maintain the positive practices previously identified. The Monitoring Team's Review of supporting documentation and interviews with the key staff responsible for managing the Emergency Response System found that the Facility met substantial compliance with the requirements of the Emergency Response Policy, 044., 9/7/2011, as verified through the following:<br>• The Facility continued to have all of the required emergency equipment, including the AEDs. Emergency equipment was secured in large black storage trunks with wheels. These were purchased to secure and make equipment readily accessible to staff during an emergency event. In addition, two additional sets of emergency equipment and portable storage trucks were available, one for use 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.<br>• A review of the completed daily Emergency Equipment and Automated Defibrillators (ADEs) Walkthrough Checklists for the past six months and the six months Summary Emergency Equipment and Automated Defibrillators (ADEs) Walkthrough Checklists found that the emergency equipment and AEDs were checked daily, if problems were identified there was evidence that corrective action was taken.<br>• The Facility had a list of all emergency equipment and AEDs that identified their location throughout the campus and had posted signs where emergency equipment | |

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| | | and AEDs were located to ensure staff knew the location of the equipment.<br>• 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 and Respiratory Therapist continued to respond to Mock Medical Emergency Drills and actual emergency scenes. Security Officers escorted the Emergency Medical Services (EMS) to the scene.<br>• The required monthly Mock Medical Emergency Drills were scheduled and noted if they were not completed. The Security Director tracked, analyzed, and provided the Mock Medical Emergency Drills Reports to the Quality Assurance Department, and other relevant staff. The Facility reported that 97% to 100% of the monthly drills were completed to ensure all required drills were completed quarterly and/or as required in areas specified in the Emergency Response Policy.<br>• The Emergency Response Committee was comprised of the following membership: Facility Director, Assistant Director of Programs, Safety Specialist, Claims Coordinator, CTD Director, CNE, NOO, Respiratory Therapist, Director Risk Management, and Medical Director.<br>• The Monitoring Team reviewed the Quarterly Drill Committee Meeting minutes including reports for all types of required drills. Drill Committee Meeting minutes for 6/20/12 and 8/30/12 were reviewed. The Committee reviewed and critiqued all types of drills performed at the Facility, including Mock Emergency Drills, Fire Drills, and Tornado Drills. The minutes consistently reported on the completed Mock Medical Emergency Drills, identified the location of drills that were missed, and took corrective action to ensure missing drills were completed. In the August meeting the issue identified by the Monitoring Team in the last compliance review regarding "partial drills" was discussed. What was agreed upon was that with the new Emergency Response Policy, all future drills will be "full drills" unless all drills in that Unit were conducted in more than one home with the same Security Officer, nursing staff, and Respiratory Therapist who participated in the first drill. They agreed this would be redundancy if they were required to repeat the drill. Since drills were clustered at the end of the month, in order to ensure they were completed timely, that the deadline for the monthly drills would be the 24th of each month. The Committee agreed to change the quarterly committee meeting to monthly. The next meeting was schedule for 9/25/12. If this committee meeting occurred, the minutes were not made available for review.<br>• 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.<br>• A review of the CTD Due/Delinquent Training List for CPR for Health Care Providers and CPR: Basic, found that six employees were delinquent in CPR for Health Care | |

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| | | Providers training and nine employees were delinquent in CPR Basic training. At the last review no employees were reported delinquent in CPR for Health Care Providers or CPR Basic training. It is essential that the Facility ensure all employees remain maintain current with their respective CPR training.<br><br>The Monitoring Team met with key Emergency Response staff to clarify "partial drills" and "full drills". They explained, as described in the August Drill minutes, that full drills were completed unless it was in in a Unit where multiple homes had conducted drills on the same shift with the same Security Officer, Nursing staff, and respiratory Therapist. Their internal procedures were revised to reflect this change. The fact that it was noted that physicians rarely participated in the Mock Medical Emergency Drills was discussed. The group decided they would include the clinic area in their schedule for drills. The Monitoring Team will follow up on drills completed in the clinic area at the next compliance review.<br><br>The Facility should continue the positive practices identified in the report to continue substantial compliance with the Emergency Response Policy. | |
| M2 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status. | The Facility's Provision M.2 Self-Assessment stated they were not in compliance with this Provision and the Monitoring Team concurs. Through review of Section M Self-Assessment, Section M Presentation Book, staff interviews, observations, and review of documents, there was 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.<br><br>The Self-Assessment reported their lowest overall compliance average for the Nursing Assessment Monitoring Tool was 92.5% in the fourth quarter to the highest overall average was 97.1% in the first quarter. The overall compliance average was 95.2%. Although the percentages for this monitoring tool showed above the 85% threshold, improvement in the quality of the content, especially in the summary and analysis of information was needed. The RN Case Manager Supervisor was in the process of developing an Assessment of Assessments to streamline and improve needed information. The Monitoring Team's findings were relatively consistently with the Self-Assessment report. It was positive to find that the Facility had implemented a system for Assessments of Assessments, and the RN Case Manager Supervisor was implementing the process to ensure the Annual and Quarterly Nursing Assessments were completed timely. Because to the new system for Assessment of Assessments coupled with the new processes for the Integrated Risk Rating Form and Integrated Health Care Plan, the compliance with this Provision will be further reviewed at the next compliance visit. | Noncompliance |

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| | | The Monitoring Team's review of Admission, Annual, and Quarterly Comprehensive Nursing Assessment for 21 Individuals (Individuals #715, #273, #552, #414, #395, #753, #33, #228, #291, #92, #490, #211, #507, #37, #461, #423, #352, #699, #3, #273, and # 296) across Units/Infirmary who were rated at high and/or medium risk for a variety of health conditions found:<br>• 18 of 21 (86%) Annual ISP Sign-in Sheets showed that the RN Case Managers attended individuals' annual ISP meeting.<br>• 21 of 21 Annual Nursing Assessments were completed. Only nine of 21 (43%) Annual Nursing Assessments were completed by the date assessments were due.<br>• 17 of 24 (71%) Quarterly Nursing Assessments were completed on time.<br>• A total of 45 Admission, Annual and Quarterly Nursing Assessments were reviewed and found:<br>o 41 of 45 (91%) Annual and Quarterly Nursing Assessments for Sections I through IX were adequately completed. This showed a significant improvement from past compliance reviews.<br>o 44 of 45 (98%) Annual and Quarterly Nursing Assessments had the required BRADEN Scale skin assessment completed.<br>o 38 of 45 (84%) Annual and Quarterly Nursing Assessments showed significant improvement in Section XI overall nursing summaries of identified nursing Diagnoses/problems. Six of 38 (16%) summaries included the individuals' health status in relation to the identified health status nursing diagnoses/problems as to whether they were improving, maintaining or regressing, as well as the effectiveness of their HMPs. This was a significant improvement from past compliance reviews.<br>o 16 of 21 (75%) individuals' had High/Medium and chronic conditions identified in Section X with HMPs developed.<br>o 42 of 45 (93%) Annual and Quarterly Nursing Assessments documented notification of individuals' respective QDDP when the assessments were completed.<br>o 35 of 45 (78%) Annual and Quarterly Nursing Assessments indicated the status of individuals' Self-Administration of Medication (SAMs).<br>• A general concern was identified in reviewing Individuals #211, #92, #, and #288 regarding sleep; all of the individuals assessed were reported to have interruption of sleep indicated but their summaries did not document further investigation as to the reason for the interrupted sleep patterns. Adequate sleep is necessary for general wellbeing and ability to stay awake and safely participate in daily activities. It is essential that abnormal sleep patterns are assessed for the underlying cause in collaboration with other relevant disciplines. | |

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| | | The Monitoring Team reviewed Nursing Assessment and Discharge Summaries for Community Living Planning for recently discharged Individuals #287, #494, #354, #505, #258, #493, and #197 found:<br>• One of seven (14%) nursing assessment and summary was completed on the Nursing Discharge Summary Form, 11/7/11. The remaining six were completed on the Comprehensive Nursing Assessment Form.<br>• Two of seven (29%) of the summaries adequately completed the required, "Special Instructions: for Medication techniques (likes/dislikes, crushed, etc.), triggers/signs/symptoms of illness/behaviors (how I communicate when I don't feel well or what makes me angry, etc.,), and special techniques to have them be cooperative. Other pertinent information (i.e.: special behaviors and what they mean, how I communicate, s/s of pain, etc.)."<br>• Six of seven (86%) summarized all of individuals' identified nursing diagnoses/problems. However, some of the summaries contained lengthy raw medical/health data without summarizing the data describing individuals' health status in relation to their identified nursing diagnoses/problems.<br>• Six of seven (86%) provided training to the receiving agency's nurses on individual's health care needs, health care plan for identified nursing diagnose/problems, and recommendations for future health care needs; however, 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. Refer to Section T for additional information.<br><br>Although there had been improvements made, and new processes put in place, the Monitoring Team agrees with the Self-Assessment that this Provision was not 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 following improvements should be considered:<br>• The Nursing Department needs to ensure that the RN Case Managers are trained on the Nursing Discharge Summary Form, 11/7/11, and use it for completing Community Living Discharge Assessments and Planning Summaries. | |
| 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, | The Facility's Provision M.3 Self-Assessment stated they were not in compliance with this Provision and the Monitoring Team concurs. Through review of Section M Self-Assessment, Section M Presentation Book, staff interviews, observations, and review of documents, there was evidence that the Nursing Department had made minimal progress toward achieving compliance with this Provision. Further, the review of this Provision found evidence that validated the Facility's Self-Assessment activities, reported data, and | Noncompliance |

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| | 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. | findings upon which they based their status of noncompliance.<br><br>The Monitoring Team's review of recent Acute Care Plans (ACPs) for infections and/or skin integrity issues and associated records for eight Individuals #365, #551, #55, #727, #289, #533, #355, and 242. Eleven ACPs were reviewed. The Monitoring Team found no improvement and identified the same problematic issues as were identified and reported in past reviews:<br>• Seven of 11 (64%) had adequate baseline data stated for the identified health problems.<br>• Eight of 11 (73%) had adequate goals stated to measure the desired outcome for the identified ACPs.<br>• Four of 11 (36%) were marginally individualized with the names and a few interventions changed to meet the individuals' health care needs. The ACPs continued to be developed from the Nursing Care Protocols for Developmental Disability Nurses' template. As reported in past reviews, these generic plans were not individualized sufficient to meet individuals' acute change in status health care needs. The ACPs continued to contain irrelevant and inappropriate information, including interventions that did not relate to individuals' need for care. In discussing this with one of the RN Case Managers, she stated she did not know how to override the template to add or delete information to individualize the ACPs.<br>• Nine of 11 (82%) 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 DSPs were more individualized to meet individuals' health care needs they were responsible for carrying out. The special instructions were written at a level that could be easily understood by the DSPs.<br>• One of five (20%) ACPs that should have been resolved contained documentation that the acute problem was resolved.<br>• Zero of 22 (0%) indicated they were developed in collaboration with other relevant disciplines. However, one ACP was for decubitus care and included recommendations from the Wound Care Nurse.<br>• Six of 11 (55%) included adequate proactive/preventative measures to reduce and/or eliminate risk indicators/problems.<br>• One of 11 (9%) specified the frequency to be monitored and the interventions to be carried out.<br>• One of 11 (9%) clearly contained documentation in the Nursing Integrated Notes that the ACP was initiated.<br>• Zero of 11 (0%) ACPs incorporated related Nursing Protocols or specific orders that required nursing interventions beyond administering medications and/or specific treatments. | |

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| | | • Seven of 11 (64%) ACPs were infection related. Zero of nine (0%) included documentation that the Infection Control Preventionist was notified of the infection. One individual was diagnosed with C-Diff. The ACP did include instructions and training of direct support professionals on standard precautions.<br>• Eight of 11 (73%) of the Integrated Progress Notes include documentation that the respective Nursing Protocols were followed, with the exception of not consistently documenting the assessment for adverse drug reactions to the antibiotic therapy. The effectiveness of the antibiotic therapy was rarely documented.<br>o Individual #551's Integrated Progress Notes on 9/24/12 through 9/28/12 documented he was receiving antibiotic therapy for pneumonia for which no ACP was initiated. The Integrated Progress Notes indicated the Antibiotic Therapy Protocol was followed, except for inconsistent documentation for adverse drug reaction. Documentation for the effectiveness of the antibiotic therapy was consistently missing. The resolution note on 9/28/12 stated that the last dose of antibiotics was given, but failed to include an assessment of Individual #551's health status in relation to response to antibiotic therapy and whether the pneumonia was resolved.<br><br>Individual #551 was diagnosed and treated for C-Diff on 10/3/12, for which an ACP was not initiated. There was no documentation that the Infection Control Preventionist was notified of the infection. There was no documentation that the direct support professionals were instructed in standard precautions for the infection. C-Diff is a highly contagious organism that requires strict adherence to standard precautions. The Antibiotic Protocol was not consistently followed.<br><br>The development and implementation of the 18 Nursing Protocol Audit Tools was a promising step forward in monitoring for compliance with the protocols. If the ACPs are continued the Nursing Department needs to continue the recommendations made in past reviews; and ensure that relevant protocols are incorporated into the ACPs, as well any other orders that require nursing interventions.<br><br>The Self-Assessment reported that Annual Nursing Care Plan Monitoring Tool's showed the lowest overall average was 76% in the fourth quarter. The highest overall compliance average was 89.4% in first quarter. The overall compliance average was 81.7% for the past two quarters. A Corrective Action Plan was deferred due to the fact that the Integrated Health Care Plan was in the process of being implemented.<br><br>The Monitoring Team's review of Health Management Plans (HMPs) for 21 Individuals #715, #273, #552, #414, #395, #753, #33, #228, #291, #92, #490, #211, #507, #37, #461, #423, #52, #699, #3, #273, and # 296 across the Units/Infirmary who were rated at high and/or medium risk for a variety of health conditions found there was no | |

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| | | significant improvement from past compliance reviews. According to the guidance for the Integrated Health Care Plan IHPC, the nursing HMPs would go away and their plans of care would be included in the IHCP. While it was positive for individuals' to have integrated plans of care, the HMPs should not be discontinued until individuals' new ISP meetings were conducted, or in the case of change of status, when a ISPAs meeting were conducted. Since the new processes for the IRRF and IHCP were so recently implemented, not enough time had elapsed to determine compliance with this Provision. The IHCPs will be reviewed at the next compliance review.<br><br>According the Self-Assessment the Nursing Care Seizure Monitoring Tool data reflected the lowest overall average at 78.7% in the second quarter and the highest overall average was 89.8% for an overall compliance of 85%.<br><br>The Monitoring Team reviewed five individuals' Seizure Records and corresponding Integrated Progress Notes for August 2012. The records were selected across the Units/Infirmary for Individuals rated at high risk for seizures, Individuals #37, #674, #554, #499, and #578. The Monitoring Team's the review of Seizure Records and associated Integrated Progress Notes found:<br>• 22 of 45 (49%) Seizure Records that were completed for seizure activity were filled out completely and correctly according to the DADS Nursing Protocol: Seizure Management Guidelines, February 2011.<br>• 28 of 45 (62%) Seizure Records were not completed on the revised Seizure Record that includes use of the Vagal Nerve Stimulator (VNS) according to the DADS Nursing Protocol: Seizure Management Guidelines, February 2011 and DADS Nursing Protocol: Vagal Nerve Stimulator, February 2011.<br>• 26 of 30 (87%) nursing Integrated Progress Notes corresponding to reports of seizure activity complied with the Nursing Seizure Management Guidelines and Seizure Protocol Card requirements for assessment and documentation. However, for individuals who used VNS the Integrated Progress Notes rarely documented whether it was used and its effectiveness. The lack of documentation was further compounded because, as reported above, over half of the seizures were reported on the outdated Seizure Record that did not include recording the use of VNS.<br>• There were Seizure Records that did not have corresponding nursing assessment and documentation of the reported seizure activity in the Integrated Progress Notes and conversely there were several nursing Integrated Progress Notes that did not have Seizure Records completed. According to the Nursing Protocol: Seizure Management Guidelines, February 2011, each seizure episode must have a completed Seizure Record and a corresponding Integrated Progress Note document assessment of the seizure activity. The data indicated the following:<br>o Seizure Records without corresponding nursing Integrated Progress Notes: | |

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| | | ▪ Five of 45 (11%) Seizure Records did not have corresponding nursing Integrated Progress Notes.<br>o Integrated Progress Notes without Seizure Records:<br>▪ Four nursing Integrated Progress Notes did not have corresponding Seizure Records.<br>• Individual #499 was administered Diastat 15 mg per rectum, on 8/5/12, at 6:33 a.m. for prolonged seizure activity on 8/5/12 at 6:25 a.m. The duration of the seizure activity and notification of the physician was not documented. Initially the nurse documented vital signs and oxygen saturation level and stated that Individual #499 made "good recovery." He was not assessed again until 6:00 p.m. The Post-Sedation Protocol was not followed. There was no Seizure Record completed for the seizure episode. On 8/26/12, at 4:46 a.m., Individual #499 was administered Diastat 15 mg per rectum on at 5:12 a.m. for prolonged seizure. The duration of the seizure was not documented, however; the physician notification was documented. The initial assessment followed the Seizure Protocol. Vital signs and oxygen saturation were assessed at 5:14 a.m. and 5:40 a.m., and a complete assessment was documented at 10:30 a.m. However the Post-Sedation Protocol was not completely followed as required, i.e., "Assess and document every 15 minutes for one hour, then every 30 minutes for one hour, then until a REACT (respiration, energy, alertness, circulation, and temperature) score of eight or greater is reached."<br><br>Summary: Although the nursing's assessments and documentation compliance with the Nursing Protocol for Seizure Management were relatively consistent with the Facility's Self-Assessment of the Seizure Management Monitoring Tool data, other problematic issues were identified. Over half of the Seizure Records reviewed were completed on the outdated Seizure Records, which did not include documentation of the VNS use and its effectiveness. Of the Seizure Records completed, they were not consistently completed as required by the Nursing Protocol: Seizure Management Guidelines and Nursing Protocol: Vagus Nerve Stimulator. Several Seizure Records did not consistently have a corresponding nursing Integrated Progress Notes describing the assessment of the seizure activity; conversely several nursing Integrated Progress Notes did not have a corresponding Seizure Record. The Post-Sedation Protocol was not followed after administering Diastat.<br><br>Although there had been improvements made, and new processes put in place, the Monitoring Team agrees with the Self-Assessment that this Provision was not 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:<br>• The removal of outdated Seizure Records from use and retraining of the nurses and direct support professionals on the updated Seizure Record as specified in the | |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Nursing Protocol: Seizure Management Guidelines, February 2011.<br>• The Seizure Record is completed for each seizure episode, as well as a corresponding nursing assessment with documentation in the Integrated Progress Note, as specified in the Nursing Protocol: Seizure Management Guidelines and Nursing Protocol: Vagus Nerve Stimulator, February 2012.<br>• The Post-Sedation Protocol is followed when individuals are administered Diastat or any other sedating medication for prolonged or intractable seizure activity.</td><td></td></tr>
<tr><td>M4</td><td>Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.</td><td>The Facility's Provision M.4 Self-Assessment stated they were not in compliance with this Provision and the Monitoring Team concurs. Through review of Section M Self-Assessment, Section M Presentation Book, staff interviews, observations, and review of documents, there was evidence that the Nursing Department had continued to move forward toward achieving compliance with this Provision and maintaining an excellent and well-organized Nursing Education Program. 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.<br><br>In order to meet compliance with this Provision the Nursing Policies, Procedures, Processes, and Protocols in which the nurses were trained must be demonstrated through actual clinical practices, as described below. Further, the review of this Provision found evidence that validated the Facility's Self-Assessment activities, regarding the reported training data.<br><br>Since the last compliance review there were no new policies, procedures, or protocols developed or implemented.<br><br>As was found in past reviews, the Nurse Educators 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 100% of the nursing required core training had been completed.<br><br>The fifteen required Annual Competencies were taught monthly to incumbent nursing staff throughout the year. The competency-based training and checks were completed according to instructions contained in the Nurse Educator's Handbook and as required by the Nursing Competency Based Training Policy. The Chart below reflects the status of the Nursing 2012 Annual Competency Training:<br><br>
<table>
<tr><td>Annual Competencies as required by Competency Based Training Policy</td><td>Date Trained</td><td>Percentage Trained</td><td>Projected Completion Date</td></tr>
<tr><td>G-Tube Insertion</td><td>9/2011</td><td>100%</td><td>Completed</td></tr>
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</td><td>Noncompliance</td></tr>
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| | | Skin Management and Wound Care | 10/2012 | 100% | Completed | |
| | | Diastat/Pre/Post Sedation/REACT Score | 11/2011 | 94% | 10/31/12 | |
| | | Medication Calculation Test | 12/2011 | 100% | Completed | |
| | | Neurological Assessment | 1/2012 | 98% | 10/31/12 | |
| | | Urine Dipstik/Hemocult | 2/2012 | 98% | 10/31/12 | |
| | | Annual Protocol Cards (18) Test | 3/2012 | 100% | Completed | |
| | | Emergency Response and Equipment | 3/2012 | 95% | 10/31/12 | |
| | | Hospital, Transfer, and Discharge | 4/2012 | 83% | 10/31/12 | |
| | | MOSES/DISCUS RN Case Managers | 1/2012 | 100% | Completed | |
| | | MOSES/DISCUS Clinical Manifestations of TD (non RN Case Managers) | 5/2012 | 91% | 10/31/12 | |
| | | Annual RN Acute Care Plans | 6/2012 | 92% | 10/31/12 | |
| | | Annual LVN Acute Care Plans | 7/2012 | 84% | 10/31/12 | |
| | | Annual Assessments of Lungs and Abdomen | 8/2012 | 86% | 10/31/12 | |
| | | Annual Skin Management and Wound Prevention | 9/2012 | 66% | 10/31/12 | |
| | | RN Physical Assessment Class/Check-Off/Unit Check-Off | 9/11/11, 6/12/12, 9/12/12 | 72% | Future Dates to be Announced (TBA) | |
| | | New Documentation Class by FNP Consultant | 9/2012 | 92% RNs 82% LVN | Future Dates TBA | |
| | | RN's Mosby Physical Assessment Review for Chapter 17 | 9/2012 | 93% | 10/31/12 | |
| | | The Facility reported that 87 RNs had been trained and had completed the final check-off for the Physical Assessment Class presented by the State Office Family Nurse Practitioner (FNP) Consultants. The remaining RNs continued to receive the training as scheduled by the Consultants. In order to reinforce the physical assessment training, the Mosby's Physical Examination Course was implemented in September 2012. Each month the Nurse Educators assigned chapters relating to specific body systems from the Mosby Physical Examination Textbook and accompanying Workbook for the RNs to review, complete the assigned activities in the workbook, and then attend class for review of the chapter before taking a written competency-based test and clinical check-off if indicated. This was a positive measure to ensure RNs' physical assessment knowledge and skills, as well as further reinforce/enhance learning from the initial Physical Assessment Class. In addition, in September, as noted above, the State Office FNP Consultants taught the RNs and LVNs an advance Documentation Class. This should further assist the nursing staff | | | | |

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| | | improve their documentation practices. However, the class was so recently taught that the effectiveness of it may not yet be evident in practice. The Monitoring Team will continue to review documentation practices at the next compliance review.<br><br>In September 2012, a Nurse Educator, Diabetic Nurse Educator, and PNMT Nurse received the "train the trainer" training by the State Office Consultants on the Medication Administration for Individuals with Dysphagia Curriculum. This training will be provided to all management level nursing staff and direct care nursing staff who administer medications. The trainers were in the process of scheduling the training to begin in November 2012. The Monitoring Team had previously attended the introduction of the Medication Administration for Individuals with Dysphagia Curriculum training at another State Supported Living Center and found the curriculum to be sound and comprehensive in teaching the normal physiology and pathophysiology of the oral pharyngeal mechanism of swallowing related to dysphagia, and the rationale for strategies for managing different dysphagia related problems. The training was competency-based with both a written test and a practicum. This training should provide the nursing staff administering medication with a better understanding of the rationale for the strategies listed on individuals' PNMPs on how to safely administer their medications. The status of the training and its effectiveness in safe administration of medication to individuals with swallowing difficulties will be reviewed at the next compliance review.<br><br>Since the last compliance review, 100% of the incumbent nursing staff had been trained on the 18 Nursing Protocols. Training on the Nursing Protocols had been included in the Annual Competencies Training and in New Nurse Orientation. A concerted effort was in process by the Nurse Managers to ensure that the nursing staff were complying with the requirements contained in the protocols. Protocol Monitoring Tools had been developed for all 18 protocols by the State Nursing Workgroup and were adopted by the Nursing Department. The Nurse Managers began using the monitoring tools in October 2012. Since these monitoring tools were just implemented, not enough time had elapsed to have developed outcome data. The Monitoring Team will review the Protocol Monitoring data at the next compliance review.<br><br>A further effort toward ensuring compliance with the protocols was demonstrated through the Monitoring Team's interview with the Eastfield Nursing Manager and observation of her review with Unit nursing staff on selected protocols during lunch time. She conducted a review of selected protocols with the Unit nursing staff daily during lunch time. Each group of nurses presented their progress notes, documentation and assessments at the review. After their presentations, there was a discussion on whether the protocols reviewed were followed and what actions were taken or missed. Any corrective action needed was made "on the spot." This was a positive method for | |

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| | | ensuring compliance with the protocol at the Unit level. The Nurse Manager was to be commended for taking this initiative to ensure compliance with the protocols.<br><br>During the Monitoring Team's tours in the Cedar Falls, Houston Park, Edegfield, and clinic area, the nursing staff casually observed were noted carrying the full set of protocols on their person, as required. The Monitoring Team's findings regarding compliance with relevant Nursing Protocols were reported throughout the other Provisions in the report.<br><br>The Nursing Department continued the Preceptor Program using high performing nurses to serve as preceptors to new hired nurses. 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. At the last compliance review the Nursing Department had begun to evaluate the effectiveness of the Preceptor Program in enhancing new nurses' performance and retention. However, data for the effectiveness of the Preceptor Program was not made available for review.<br><br>The New Nurse Orientation process continued for six weeks. An overview of Intermediate Care Facility and Settlement Agreement requirements, as well as specific standards, core policies, and procedures were taught in orientation. During orientation the new nurses' demonstrated skills and knowledge in the classroom by performing return demonstrations and/or written competency-based testing in a non-care setting. During the two weeks of on-the-job training in the care units the new nurses demonstrated skills and knowledge to the satisfaction of their assigned Preceptor and Unit Nurse Manager prior to independently caring for individuals. The Unit Nurse Manager referred nurses who needed review or remediation back to Nursing Education for extra training.<br><br>The Nurse Educators continue to provide the State's mandated Clinical Indicators of Health Status Change Class at CDT's New Employee Orientation. This class had become part of the required training in the New Employee Orientation.<br><br>It was positive to learn from the State Office Nursing Coordinator that the Central Texas Chapter for the Developmental Disability Nursing Association (DDNA) was established in May 2012 at the DDNA Conference. Although this is not a requirement for the Settlement Agreement, the value of having a Texas DDNA Chapter will provide the RNs and LVNs who provide services to individuals with developmental/intellectual disabilities, both in State Supported Living Centers and in the community setting at large, with opportunities to foster their nursing knowledge and expertise about current practices in DD nursing, thereby improving individuals care, services, and quality of life. The membership in state | |

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| | | chapter allows local chapters to be formed, online learning opportunities, ability to earn continuing education units (CEUs), attend national conferences, and certification in this specialty area of nursing practice. She also stated DDNA had approved CEUs for the oral medication, Risk Process, and Integrated Healthcare Plan courses developed by the State Office. This not only provides the nurses with the opportunity to earn CEUs, but more importantly having their approval lends credibility to the quality of these courses.<br><br>The Nursing Department and the Nurse Educators should maintain the positive practices identified in the report and continue to reinforce and 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. 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; 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. | |
| M5 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual. | The Facility's Provision M.5 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, observations, and documents, provided evidence that the Nursing Department had made minimal progress toward achieving compliance with 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. However, reports regarding the Self-Assessment of skin integrity and infection control items were reported in the M.1 Provision of the report. In the future the Nursing Department should report those Self-Assessment items in the M.1 Provision.<br><br>Since the last compliance review, the At Risk Individual Policy Number: 006.3 was revised on 8/24/12. The policy revision also resulted in revisions to the Individual Support Plan (ISP), Integrated Risk Rating Form (IRRF), and Integrated Health Care Plan (IHCP) processes. As was reported in the Self-Assessment, the RN Case Manager Supervisor and RN Case Managers received training on the revised policy, ISP, IRRF, and IHCP processes on August 28 -30, 2012 by the State Office FNP Consultants and Nursing Coordinator. The RN Case Managers for two identified Interdisciplinary Teams (IDTs) have entirely implemented the new IRRF and IHCP processes. The other RN Case Managers and their IDTs will implement the new processes in the middle of October 2012. | Noncompliance |

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| | | The Monitoring Team review the revised At Risk Individual Policy and associated ISP, IRRF, and IHCP processes, along with the training material presented by the State Office staff. The review found the revised processes and related training material significantly improved over the previous policy, Integrated Risk Rating and Action Plan processes, and training material. The revised Integrated Risk Rating Form, as well as the Integrated Health Care process, improved the process for identifying risk ratings by grouping inter-related risks factors together,.<br><br>After reviewing the IRRF and IHCP material, the Monitoring Team identified several concerns and discussed them onsite with the State Office Nursing Coordinator and FNP Consultant. The use of the nursing diagnoses for identifying the risk related health problem for each risk group was misleading, particularly if the North American Nursing Diagnosis Association (NANDA) diagnoses were used. These diagnoses specifically relate to nursing practice. Other disciplines do not use these diagnoses and probably are not familiar with their interpretation. Some of the NANDA diagnoses are vague and difficult to understand precisely what is being described. Even if nursing diagnoses per se were used they may not be as comprehensive in describing individuals' overarching health problem related to the group of risks for which it was intended. Further, calling the individuals' health problem a nursing problem was again misleading. It was the individuals' problems and the diagnoses of the problems should be clearly described in terms that are not specifically discipline driven.<br><br>Further, the responsibility for the RN Case Managers to develop the IHCP places a significant weight of responsibility on them and additional time to prepare the plan. Time management studies should be considered to assess whether the RN Case Managers have time to adequately prepare the IHCPs in addition to their other responsibilities. As was found in past compliance reviews, the other disciplines frequently failed to provide the RN Case Managers with their data 10 days prior to the ISP annual planning meeting. This resulted in either the RN Case Managers spending a concerted amount of time researching other disciplines' clinical data or the data were missing from the risk assessments. The respective IDT's QDDP and/or designated staff should ensure that other disciplines enter their individuals' clinical assessment data and recommendations for supports and services at least 10 days prior to the individuals' ISP meeting in order for the RN Case Managers to have adequate time to prepare the draft IRRF and IHCP.<br><br>According to the guidance for the IHPC, the nursing HMPs would no longer be used and their plans of care would be included in the IHCP. Although it was positive for individuals to have integrated plans of care, the HMPs should not be discontinued until new ISP meetings were conducted, or in the case of change of status, when ISPAs meeting were conducted. The changes for risk rating assessments and health care planning also | |

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| | | impact compliance with M.2 and M.3. Consequently, with the changes so recently implemented, the data was not yet available to determine the degree of compliance with this Provision or Provisions M.2 and M.3.<br><br>The Monitoring Team attended the ISP meeting on 10/10/12 for Individual #250 where the revised IRRF and IHCP were used. The facilitator who lead the meeting was well organized and ran the meeting efficiently and effectively. All of Individual #250's relevant support staff attended the meeting, except for the pharmacist. It was apparent the staff were familiar with the revised process for IRRF and IHCP. The first part of the meeting addressed his preferences, strengths, and reports of injuries, particularly as related to self-injurious behaviors. His direct support professional knew him well and offered substantive information to the team, such as his preferences for drinks. His mother was present and offered additional preferences and health information. The RN Case Manager effectively and efficiently directed and presented the clinical risk rating data for team discussion and disposition. Most staff actively participated but a few did not speak. The facilitator often prompted the team to clarify information and to provide more discussion on some of the risk ratings. It was also positive that the IDT had a scribe present who documented the discussion and decisions for additional supports and services after each group of risk ratings were reviewed.<br><br>Although the Monitoring Team found some general improvement in the quality of the clinical data presented for each risk factor, the IDT needs continued improvement in ensuring all relevant clinical data are assessed and analyzed and correlated with other related risk ratings to correctly identify each risk. Some of issues of concern and examples of good interdisciplinary process are listed below in the report:<br>• The dental clinical risk data was presented by the dentist. The mother was able to offer additional information regarding Individual #250's chronic problem with blisters in his mouth that was not included in the dental clinical risk data. Subsequently, this information was added, as well as a plan for supports and services to address the mouth blisters.<br>• The clinical risk data for constipation reported that he was independent in toileting and it was challenging to determine his elimination patterns. His direct support professional was able to inform the team of his bowel elimination patterns. It was regrettable that when gathering the information that the RN Case Manager did not consult with the direct support professional staff regarding his elimination patterns. The direct support professional staff who know individuals well should be interviewed as part of gathering clinical data for risk; failure to do so results in overlooking vital clinical information. In addition the mother explained that after bowel elimination the Individual needed his personal hygiene addressed. Additional supports were put into the plan to address personal hygiene. | |

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| | | • The Infection clinical risk data indicated that he had chronic ear infections for which he was treated 10 times last year for otitis media and externa and had tubes in his ear. There was discussion regarding leaving his risk rating at medium because he had ear tubes. The facilitator asked the team if he did not have ear tubes what would be his risk rating. After discussion, the team decided to change the risk rating for infections to high.<br>• The clinical risk data placed him for medium cardiac risk due to hyperlipidemia with significantly elevated triglycerides for which he was prescribed three different medications for control. He was also diagnosed with metabolic syndrome and had a strong family history for heart attacks and strokes. His mother reported that he also snores at night. This was validated by his direct support staff. Snoring was not included in his clinical risk data. The team added a sleep study to his support plan. Based on the clinical risk data and discussion, it was concerning to the Monitoring Team why his cardiac risk was not changed to high.<br>• His risk rating for diabetes was low based on fasting blood sugar (FBS) that was within normal limits. However, the date for the last FBS was not included. He had not had a baseline HbA1c for diabetes. The team added this test to his support plan. It was of concern based on the diagnoses of metabolic syndrome why he was not rated at least at medium risk for diabetes. According to the DSSLC Pharmacy Metabolic Syndrome Policy, individuals diagnosed with Metabolic Syndrome would be rated at least at medium risk.<br>• The clinical risk data placed him at high risk for skin integrity due to chronic skin conditions/infections (seborrhea dermatitis and keratosis pilaris; acne, tinea pedis, corporis, and cruis; and hyperhidrosis) and self-injurious behaviors (picks at skin) with a diagnosis of Cornelia de Lange Syndrome. The clinical risk data did not include a baseline BRADEN skin assessment.<br>• The clinical risk data rated him low for hypothermia; however, there was no baseline temperature data included.<br><br>The Monitoring Team reviewed six of the most recently completed Integrated Risk Rating Forms and Action Plans for Individuals #438, #298, #175, #192, and #19. All of the Integrated Risk Rating Forms and Risk Actions Plans were completed on the previously used forms. The finding included:<br>• Zero of six (0%) Integrated Risk Rating Forms adequately provided integrated clinical risk data to support each of the risk rating categories. There was no appreciable improvement from the last compliance review. They did not meet the requirements for compliance with Section I of the Settlement Agreement.<br>• Zero of six (0%) Risk action Plans adequately provided an integrated Risk Action Plan for each of the risk rating categories. There was no appreciable improvement from the last compliance review. They did not meet the requirements for | |

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| | | compliance with Section I of the Settlement Agreement.<br><br>The Monitoring Team reviewed 18 Aspiration Trigger Data Sheets and Integrated Progress Notes when triggers were identified for September 2012, on Individuals rated at high risk for aspiration #715, #478, #639, #11, #134, #211, #699, #187, #503, #291, #92, #460, #507, #461, #352, #633, #37, and #3 and found:<br>• Zero of 18 (0%) sheets had individualized aspiration triggers identified.<br>• Two of 18 (11%) sheets were completely filled out daily, on each shift, by the direct support professional for all required trigger data.<br>• Four of 18 (22%) sheets were reviewed and initialed daily by the nursing staff on the 6-2 shifts as required.<br>• Five of 18 (28%) sheets were reviewed and initialed by the nursing staff daily on the 2-10 shifts as required.<br>• Four 18 (22%) sheets were reviewed and initialed by the nursing staff daily on the 10-6 shifts as required.<br>• Zero of 18 (0%) sheets were reviewed and initialed, at least daily Monday through Friday, by the RN Case Managers as required. This was no doubt related to the fact that the RN Case Managers were not trained to check the Aspiration Trigger Data Sheet for compliance.<br>• Six of 18 (33%) individuals had one or more triggers marked throughout the month.<br>• Zero of six (0%) individuals identified with triggers had follow-up nursing assessments documented in their Integrated Progress Notes:<br>o Individual #633 had the following cough with struggle trigger episodes marked on the Aspiration Trigger Data Sheet for which there were no follow-up nursing assessments documented in the Integrated Progress Notes:<br>▪ 9/10/12 four episodes were reported on the evening shift.<br>▪ 9/11/12 three episodes were reported on the evening shift.<br>▪ 9/13/12 one episode was on the evening shift.<br>▪ 9/14/12 two episodes were reported on the evening shift.<br>▪ 9/16/12 five episodes were reported on the night shift.<br>▪ 9/30/12 two episodes were reported on the evening shift.<br>o Individual #461 had the following wet vocal quality/gurgling voice/wheezing trigger episodes marked on the Aspiration Trigger Data Sheet for which there were no follow-up nursing assessments documented in the Integrated Progress Notes:<br>▪ 9/17/12 two episodes were reported on the day shift and two episodes were reported on the evening shift.<br>o Individual #478 had the following cough with struggle trigger episode marked on the Aspiration Trigger Data Sheet for which there were no | |

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| | | follow-up nursing assessment documented in the Integrated Progress Notes:<br>▪ 9/2/12 one episode was reported on the evening shift.<br>o Individual #639 had the following trigger episodes marked on the Aspiration Trigger Data Sheet for which there were no follow-up nursing assessments documented in the Integrated Progress Notes:<br>▪ 9/24/12 one episode of cough with struggle reported on the evening shift.<br>▪ 9/28/12 one wet vocal quality/gurgling voice/wheezing trigger episode on the day shift.<br>o Individual #715 had the following trigger episodes marked on the Aspiration Trigger Data Sheet for which there were no follow-up nursing assessments documented in the Integrated Progress Notes:<br>▪ 9/22/12, 9/28/12 one episode of cough with struggle reported on the evening shift.<br>▪ 9/28/12 one episode of cough with struggle reported on the evening shift.<br>▪ On 9/29/12 eight episodes of cough with struggle were reported on the night shift.<br>▪ 9/30/12 one episode of cough with struggle reported on the day shift and one wet vocal quality/gurgling voice/wheezing trigger episode on the day shift.<br>o Individual #134 had cough with struggle trigger episodes marked on virtually every shift on the Aspiration Trigger Data Sheet for 29 of 30 (97%) days of the month for which there were no follow-up nursing assessments documented in the Integrated Progress Notes.<br><br>The records reviewed above were derived from a cross-section of records across the Units/Infirmary of individuals with high risk ratings, who required daily monitoring, documented on the Aspiration Trigger Data Sheets. After review of the above records, the Monitoring Team was extremely concerned over the lack of compliance with the Aspiration Trigger Monitoring Guideline requirements by the direct support professionals, nursing staff, and PNMT, as well as lack of adequate oversight by Residential, Nursing, and Habilitation Management to ensure that individuals at risk for aspiration were monitored daily on every shift and followed-up appropriately. The Facility urgently needs to ensure that all disciplines responsible for monitoring individuals at high risk for aspiration follow the required Aspiration Trigger Monitoring Guidelines/Instructions.<br><br>Since the last compliance review, it was promising to find that the PNMC had developed and implemented a comprehensive Fall Prevention Program Resource Manual. It was based upon data reviewed during their trend analysis meetings and through their own | |

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| | | review of clinical indicators. The PNMC was responsible for the development, implementation, oversight and evaluation of the program. Implementing the Fall Prevention Program was the responsibility of the interdisciplinary teams, along with the assistance and support of Unit Injury/Incident Review Teams (IRT), IMRT, and PNMT. The goals of the program was to decrease the number of falls and decrease injuries related to falls. The QA/QI Council was responsible for fall related quality improvement efforts. There was no nursing documentation related to fall prevention in the documents reviewed. The Monitoring Team will follow up with nursing's involvement with fall prevention at the next compliance review. Refer to Section O for more information regarding fall prevention.<br><br>The Facility's Self-Assessment stated they were not in compliance with this Provision, and the Monitoring Team concurs. This Facility is far from meeting compliance with this due to recent changes put in place to foster integration of services through the Integrated Risk Rating form and Integrated Health Care Plan processes. The Monitoring Team will follow up on progress made with implementation of these processes at the next compliance review. | |
| M6 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. | The Facility's Provision M.6 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, observations, 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.<br><br>Since the last compliance review, the Facility had fully implemented the Medication Variance Policy, 053 and revised the Pharmacy Policy, Number 27.1 to include changes to Medication Variance Tracking and Procedures. The purposes were to: Identify and report all actual variances within departments to identify trends and implement processes to improve safety of individuals served by enhancing 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.<br><br>The Facility continued to have a comprehensive Medication Variance Database using a root cause analysis approach. The database aggregated, analyzed, and trended data by month, Unit/Infirmary and Facility-wide, shift, number of variances type, Severity Index by Categories, nurses who committed the variances, individuals for which the variances | Noncompliance |

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| | | were committed, contributing factors, and medications associated with the variance. The data were represented by bar graphs including the number of variances 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 May 2012 through August 2012 that had been aggregated, analyzed and trended.<br><br>The Monitoring Team reviewed the Units/Infirmary and Pharmacy Pre-Medication Variance Committee Meeting Minutes, April through August 2012. These reports were presented at the Monthly Medication Variance Committee Meetings. Pre-Medication Variance Committee had a robust and comprehensive system for analyzing, trending and taking corrective action on medication variances. Pre-Medication Variance Committee was comprised of: Nursing Administration, QA Nurse, Nurse Managers, and Chief Pharmacist who reviewed, analyzed, and trended monthly medication variance data reports for each Unit/Infirmary, pharmacy, and Facility-wide by:<br>• Total number of variances<br>• Units/Infirmary and shift where the variances occurred<br>• Severity Index Categories and types of medication variances within each category<br>• Contributing factors<br>• Nurses who committed the variance<br>• Individuals for which the variances were committed<br>• Medications associated with the variance<br>• The Pharmacist analyzed and trended medication variances based on dispensing and order entry.<br>• Calculated the rate of occurrence based on the total number of medication doses administered by Unit/Infirmary and Facility-wide. Rates were calculated monthly for each Unit, Infirmary, and Facility-wide by number of doses administered per day, multiplied by the number of days in the month to equal the total doses administered. The total number of doses was divided by the number of medication variances to equal the rates. The rates were converted to represent the percentages of medication variance. Although this data was produced, it could not be discerned from the minutes how the rates and percentages were used in decision making. This issue will be further explored at the next compliance review.<br><br>In addition, the Pre-Medication Variance Committee reviewed and discussed Units/Infirmary and Pharmacy data and based on the conclusions took appropriate corrective action on identified medication variances. The data was also analyzed and trended Facility-wide, and based on the conclusions appropriate corrective action was taken for identified systemic medication variances. In addition, the Committee reviewed, | |

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| | | analyzed, trended, and discussed, Adverse Drug Reactions and Medication Administration Observations, and took appropriate corrective action for identified variances and/or other deficiencies. Other substantive medication administration practices were also reviewed, discussed, and plans of corrective action developed when indicated. The information derived from the monthly Pre-Medication Variance Committee Meeting Reports was presented at the Facility's monthly Medication Variance Committee Meetings. All corrective actions identified the responsible staff and timeline for completion. However, the Monitoring Team did not find in the minutes follow-up data to indicate that medication variance corrective actions were actually taken or that the effectiveness of the various corrective actions taken for medication variances related to the specific disciplines responsible for medication administration practices was checked and evaluated. The Medication Variance Committee should evaluate and report in the minutes the effectiveness of corrective actions taken for medication variances committed by the respective disciplines responsible for medication administration practices.<br><br>The Medication Variance Committee continued to have a sound structure for comprehensively analyzing, trending, and taking corrective action for medication variances committed by the respective departments responsible for medication administration practices. The Committee's core membership was comprised of: Chief Pharmacist (chair), Facility Director, Medical Director, Chief Nurse Executive, Director of Residential Services, and Director of Quality Assurance.<br><br>The Monitoring Team attended the Medication Variance Committee Meeting on 10/10/12. All Committee core members attended the meeting and actively participated in discussions, problem solving, developing corrective action, and follow-up actions. Since the last compliance review, the Committee's ability to collect, aggregate, analyze, and trend medication variance data as well as to represent it meaningfully to use in improving medication administration practices had significantly improved.<br><br>Since the last compliance review, the Chief Pharmacist and CNE had worked with the Data Analyst to clarify some disparity found in the data. During the Committee's review of medication variance data, it was identified that while the pharmacy reported all dispensing/order entry medication variances (Category A, variances that did not reach the individual), these variances were reported into a separate database and were not included in the overall medication variance counts along with the nurses' variance. The State Office Nursing Coordinator reminded the Committee of the State Supported Living Center Medication Guidelines, issued 1/24/12. The Guidelines stated, "Category A medication variances must be documented and counted with the total medication variances, whether they are "potential error" in the pharmacy, with medical, or with nursing. A Category A is a circumstance where there is a potential for an error to occur, | |

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| | | even if the medication never leaves the pharmacy or reaches the individual. It is important that all medication variances are counted accurately, and then trended to identify areas for improvement. A facility should not only track total number of variances, but also track by category and by department." After discussing the Guidelines, Committee decided that the Pharmacy Category A medication variances would be included in the total variances.<br><br>Although medical providers' medication variances were addressed, their variances were not counted in the total medication variances. When adding the Pharmacy's and medical providers' medication variance counts to the total counts, along with nursing's count, the number of medication variances will no doubt show an overall increase, but the total count would be accurate for the Facility. This would be a positive measure, which would identify all medication variances so that systemic improvements could be made to reduce the number of occurrences. The Medication Variance Committee should ensure that all medication variances are counted accurately, and then trended to identify areas for improvement. Medication variances should not only be tracked by the total number of variances, but also tracked by category and by department. This includes all types of Category A medication variances.<br><br>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 the Monitoring Team's attendance at the Pharmacy and Therapeutics Committee on 10/9/12. 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. Refer to Section N for more information regarding the Pharmacy and Therapeutics Committee minutes and the Committee meeting on 10/9/12 as well as for Medication Variance information.<br><br>The Monitoring Team's review of the overall monthly number of nursing medication variances (pharmacy and medical providers were not included) reported in the pre-Medication Variance Committee Reports March 2012 through August 2012 are listed below:<br>• March – 59<br>o (Facility-wide 9,449 medication doses were administered per day totaling 283,470 doses per month. Fifty nine medication variances occurred out of 283,470 or a rate of 0.00020813 or 0.02%)<br>• April – 69<br>o (Facility-wide 9,449 medication doses were administered per day totaling | |

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| | | 283,470 doses per month. Sixty nine medication variances occurred out of 283,470 or a rate of 0.00020813 or 0.02 %)<br>• May – 59<br>o (Facility-wide 9,449 medication doses were administered per day totaling 283,470 doses per month. Fifty nine medication variances occurred out of 283,470 or a rate of 0.00020813 or 0.02 %)<br>• June – 45<br>o (Facility-wide 9,449 medication doses were administered per day totaling 283,470 doses per month. Forty five medication variances occurred out of 283,470 or a rate of 0.00020813 or 0.02%)<br>• July – 45<br>o (Facility-wide 9,449 medication doses were administered per day totaling 283,470 doses per month. Forty five medication variances occurred out of 283,470 or a rate of 0.00020813 or 0.02%)<br>• August – 36<br>o (Facility-wide 9,449 medication doses were administered per day totaling 283,470 doses per month. Thirty six medication variances occurred out of 283,470 or a rate of 0.00020813 or 0.02%)<br>• September data was not yet available at the time of the compliance review.<br>The accuracy of the above data was questionable since the same number of doses was reported for each month and the same exact rate was reported monthly. The Facility did not indicate how the number was determined. The Facility needs to ensure accuracy of calculating the number of medication doses and rate of medication variances.<br><br>Although it was positive to find that the monthly number of medication variances had showed some progressive decrease in June, July, and August, considering the high volume of medication doses given monthly, it was questionable as to whether all medication variances were being identified and reported. The Facility should not be lulled in to a false sense of confidence when looking at the low rates and percentages of medication variances. There were some discrepancies between the number of medication variances reported by the monthly Pre-medication Variance Committee Reports and the final March through August 2012 Medication Variance Reports from the database. There was no plausible explanation identified for the discrepancies. This issue will be clarified at the next compliance review.<br><br>The Monitoring Team's review of the monthly Pre-Medication Variance Committee Reports found that the most frequently committed variances were for Category C., which included omission of medications as the leading type of variance, followed by wrong dose, transcription errors, wrong medication, wrong time, and wrong individual. However, in the July and August 2012 in data for Category A, there were at least 61 | |

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| | | variances found for nurses' missing initials on the MARs, of which none were reported as a variance. This was a significant problem and skewed the actual count of the nursing medication variances, as well as the overall total count of medication variances committed. According to the Medication Variance Guidelines, mentioned above, all of these Category A medication variances for missing initials on the MARs variance should have been reported and counted as a medication variances. The Nursing Department should ensure that all medication variance are reported, including Category A medication variances.<br><br>In the August 2012 Medication Variance Committee Minutes there were 61 medication variances reported for the physicians, which were described as documentation variances. The physician's medication variances should include the specific type of physicians' medication variances, including potential incorrect medications prescribed, incorrect doses, wrong individual, missed allergies, and missed adverse reaction, as well as any other type of medication variance.<br><br>The Monitoring Team's review of the past three months MARs for 21 individuals found 162 medications that were not initialed by the nurses as having been administered. Now that the Nurse Managers were monitoring more consistently, coupled with the Medication Variance's Committee's recognition that failure to initial medications on the MARs constitutes a medication variance; it was expected these variances will be reported and appropriate corrective action taken to prevent/reduce these variances.<br><br>The Monitoring Team reviewed 10 of the most recent Medication Variance Reports. There was significant improvement in correctly completing the Medication Variance Reports from previous reviews. The Finding included:<br>• Ten of 10 (100%) Medication Variance Reports were completed correctly.<br>• Eight of 10 (80%) medication variances were discovered and reported within 24 hours. Two medication variances were not discovered for 11 days each. One medication variance was due to a transcription error. Upon on discovery the supervising RN took appropriated corrective action. The nurse was retrained and required to have another nurse check and initial his transcriptions until deemed competent to independently transcribe orders. The other medication variance was due to a pill found in an individual's drawer in the medication cart on cart exchange by the pharmacy. It was not determined when the dose was missed or the nurse who committed the medication variance. It was positive to find that a Medication Variance Report was completed for the medication found left in the medication cart.<br>• Ten of 10 (100%) medication variances were graded correctly on the Severity Index as Category C: Variances that reached the individuals but did not cause harm.<br>• Ten of 10 (100%) medication variances were reported to the respective physician | |

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| | | upon discovery.<br>• Ten of 10 (100%) medication variances had appropriate corrective action taken by the respective supervising RN.<br>• Ten of 10 (100%) medication variances had data describing why the variances occurred.<br>• Nine of 10 (90%) medication variances were committed by full time nurses.<br>• The 10 most recent Medication Variances submitted were for Houston Park and Cedar Falls. These Units' trends showed.: Seven of 10 (70%) occurred in Houston Park Apartments 513 B (2) and C, 514 B and C, and 515 B and D. Three of 10 (30%) occurred in Cedar Falls Apartments 512 B (2) and 502D.<br><br>The Monitoring Team reviewed the QI/QA Council Data Analysis Reports, as was reported in the Self-Assessment, for the Nursing Care: Medication Administration and Documentation, which showed the lowest overall average of 98.2% in the second quarter and the highest overall average in the fourth quarter of 99.9%. There were no CAPs because none of the data fell below 85% compliance.<br><br>As was reported in the Facility's Self-Assessment, the 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 fully implemented. This was due in part for the temporary loss of a QA Nurse. A new QA Nurse was recently hired and was beginning to resume assigned responsibilities relevant to medication administration practices. The Monitoring Team will review the status of the inter-rater reliability system for medication administration observations at the next compliance review.<br><br>According to the Self-Assessment the Nursing Department had recently developed and began to pilot a Nurse Manager Monitoring Tool, which included items to be monitored for the medication carts, cabinets, and medication rooms, as well as Medication Administration Records (MAR). Data from the items were not submitted for review, possibly because data from the tool was not yet available. Therefore, it was not possible to determine the Nursing Department's status of medication administration practices related to these issues. The Nursing Department should ensure that Nurse Managers, at least, monthly complete Medication Room Audits; MAR Audits; Universal Signatures Sheet Audits; and Control Drug Log Audits.<br><br>The Unit Nurse Managers and QA Nurse conducted quarterly Medication Administration Observations on nursing staff who administered medications. The Quality Assurance Department compiled monthly reports for the Units/Infirmary and Facility-wide percentage of compliance found for Medication Administration Observations. The report | |

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| | | included the number of nurses observed and identified deficiencies on the items on the tool that fell below 85% compliance that required corrective action at the Unit/Infirmary level as well as systemic issues identified on the overall report for the Facility. Since the last compliance review, the data continued to show progressive improvement locally and systemically. The Facility-wide data showed the percentages for monthly compliance with the monitoring tools:<br>• April - 94%<br>• May - 99%<br>• June - 98%<br>• July – no data was submitted for review (This was during the time they were without a QA Nurse who prepared the reports.)<br>• August – 96%<br>• September – 97%<br><br>The Monitoring Team reviewed the Units/Infirmary monthly as well as the Facility-wide Medication Administration Observation Reports. For items on the Medication Observation Tools that fell below 100% correction was done "on the spot" by the observer. Completed observation forms were sent back to the Unit/Infirmary Nurse Managers for review and further local and systemic corrective action when indicated. The finalized observation forms were sent to the Quality Assurance Department to compute the percentage and add comments and corrective action on the reports. The outcome of the Medication Administration Observations was presented at the monthly Medication Variance Committee Meetings for further discussion and corrective action when indicated. This was verified through a review of the various Monthly Pre-Medication Variance Committee Meetings Minutes and Medication Variance Committee Meeting Minutes.<br><br>The proposed revised Medication Administration Observation Tool was reviewed and discussed with the CNE and State Office Nursing Coordinator. They explained that while they could not formally weight the items on the tool, they were identifying and indicating on the tool items that were essential to comply with 100%. Failure to comply with those items 100% would require retraining. The outcome of the revised Medication Administration Tool will be reviewed at the next compliance review.<br><br>The Monitoring Team, accompanied by the NOO and Unit Nurse Manager, conducted medication administration observations in the Infirmary at 4:00 p.m. on 10/10/12. The medications were administered enterally. Observations were conducted using the State/Facility's' standardized Medication Administration Observation Tool, for oral and enteral administration. The nurse observed consistently followed correct medication administration procedures for enteral administration. The nurse reviewed the PNMP | |

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| | | before beginning to administer the medication and was able to verbalize the rationale the PNMP. She informed the individual of his PNMP and medications administered. This was a significant improvement from past medication administration observation. It was apparent that the Nursing Department had emphasized more training on the PNMP's Medication Administration section since the last compliance review. The nurse checked each medication against the Medication Administration Record (MAR) as they were removed from the cart, as they were prepared for administration, and after they were administered. Medications were initialed on the MAR as they were administered. The nurse maintained proper hand washing throughout the medication administration. Waste products were properly disposed of and the medication cart was kept clean. Privacy was provided in the semi-private room by closing the privacy curtain. The individual was treated with courtesy and respect. The Master MAR Notebook contained the current month's Universal Signature Sheet for all nurses administering medications, as well as individuals PNMPs. The MAR was checked and found that all required information was present except the stop dates for the medications prescribed. Having the stop dates printed on the MARs is essential to flag when the medications need to be discontinued or orders renewed. The Pharmacy should ensure that start and stop date are included on the Mediation Administration Record for all medications.<br><br>After the medication administration observation the Infirmary's Medication Room was reviewed. It was positive to find the medication clean and well organized. The Refrigerator Temperature Logs for the last three months were completed daily and the appropriate temperatures were maintained as required for safe storage of medications. The Control Drug Logs for the last three months contained co-signatures daily at the change of shifts. There were no expired medications found and oral and topical medications were stored properly. One individual's Diastat box in the refrigerator had the break-away lock missing and was immediately returned to the pharmacy for replacement.<br><br>The Monitoring Team followed up from the last compliance review with the Nurse Managers for Cedar Falls and Houston Park on issues identified at the last review:<br>• It was positive to find they had received two large storage shelves for medication. The stock medication was checked regularly and rotated to prevent expired medication from occurring.<br>• The Refrigerator Temperature Logs for the past three months showed the temperatures were checked and recorded daily. Temperatures were maintained at the required temperatures to ensure safe medication storage.<br>• The Control Drug Logs reviewed in Houston Park 14 Band C for the last three months contained co-signatures daily at the change of shifts. This showed significant improvement from the last review. | |

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| | | • The MAR Notebooks in Houston Park 14 Band C were reviewed and both contained a current month's Universal Signature Sheet of nurses administering medications. Both MAR Notebooks contained individuals' PNMPs. PNMPs were updated at the time of individuals' annual ISP or when there was significant change in status that required revision of the PNMPs. The Nurse Managers stated that when PNMPs were updated or revised, the PNMT coordinators provided a copy to the Unit/home charge nurse and/or primary nurse and provided training on the updated and/or revised PNMP. Then, the 24 Hour Shift Report noted that the PNMP was updated or revised. There was no individual specific training provided to all direct care nurses on the PNMP unless there was special circumstance that required that all nurses were trained. Two examples were provided that demonstrated when Individuals #427 and #793 had significant changes in status that required revision of the PNMPs, all nursing staff received individualized training on the revised PNMP. Copies of the Habilitation Therapies Training Sign-in Sheets were provided that validated the training occurred.<br><br>It was positive to find, as was previously recommended, that a Nurse Educator, Diabetic Nurse Educator, and PNMT Nurse received "train the trainer" training by the State Office Consultants on the Medication Administration for Individuals with Dysphagia Curriculum. This training will be provided to all management level nursing staff and direct care nursing staff who administers medications. The trainers were in the process of scheduling the training to begin in November 2012. This training should provide the nursing staff administering medication with an understanding of the rationale for the strategies listed on individuals' PNMPs on how to safely administer their medications.<br><br>As was found at the last compliance review, the apartments continued to lack medication rooms from which to administer medications that would afford individuals with privacy and limit distractions for the nurses, except for Building 528 for Apartments A, B, C, and D, where medication rooms were converted from closets. 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 privacy screen to provide some degree of privacy. For individuals who received medications enterally, they were taken to a private room. The Facility should continue to consider the risk and benefits of not having medication rooms where individuals could receive medications in privacy and where the nurses administering medication were free from distractions to prevent medication errors/variances.<br><br>Although there had been improvements made, and new process put in place, the Monitoring Team agrees with the Self-Assessment that this Provision was not in compliance. In order to meet compliance with this Provision of the Settlement | |

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| | | Agreement, the positive practices identified in the report must be maintained and improvements made in other practices. The Medication Variance Committee should consider the following improvements should be considered:<br>• The Medication Variance Committee should evaluate and report in the minutes the effectiveness of corrective actions taken on medication variances committed by the respective disciplines responsible for medication administration practices.<br>• The Medication Variance Committee should ensure that all medication variances are counted accurately, and then trended to identify areas for improvement. Medication variances should not only be tracked by the total number of variances, but also tracked by category and by department. This includes all types of Category A medication variances. This includes the specific type of physicians' medication variances, including for potential incorrect medications prescribed, incorrect doses, wrong individual, missed allergies, and missed adverse drug reactions, as well as any other type of medication variance.<br>• The Nursing Department should ensure that Nurse Managers, at least, monthly complete Medication Room Audits; MAR Audits; Universal Signatures Sheet Audits; and Control Drug Log Audits.<br>• The Pharmacy should ensure that start and stop date are included on the Medication Administration Record for all medications. | |

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

1. The Nursing Department should collaborate with other relevant disciplines to ensure that Daily Active Treatment Specialist Records and Flow Records for Active Treatment Programs (ATPs) records are completed daily on each shift. (Provision M.1)
2. The Hospital Liaison Nurses should also review the Integrated Progress Notes and associated documentation forms for individuals admitted and discharged from the hospital and/or emergency room to ensure compliance with the Nursing Protocol: Hospitalization, Transfers, and Discharges, June 2011. (Provision M.1)
3. The Diabetic Nurse Educator should review diabetic health care plans to ensure they are current and reflect the actual interventions carried out specific to the individuals. (Provision M.1)
4. The Wound Care Nurse should review skin integrity/decubitus health care plans to ensure they are current and reflect the actual interventions carried out specific to the individuals. (Provision M.1)
5. The Nursing Department should ensure that the nursing staff notifies her when infections are diagnosed and treated. (Provision M.1)
6. The Infection Control Preventionist Nurse should review all infection health care plans to ensure they include the Antibiotic Therapy Protocol requirements and reflect the actual interventions carried out specific to the individuals. (Provision M.1)
7. The Nursing Department needs to ensure that the RN Case Managers are trained on the Nursing Discharge Summary Form, 11/7/11, and use it for completing Community Living Discharge Assessments and Planning Summaries. (Provision M.1)
8. The Nursing Department should ensure: (Provision M.3)
    a. The removable of outdated Seizure Records from use and retrain the nurses and direct support professionals on the updated Seizure Record as specified in the Nursing Protocol: Seizure Management Guidelines, February 2011.
    b. The Seizure Record is completed for each seizure episode, as well as a corresponding nursing assessment with documentation in the

Integrated Progress Note, as specified in the Nursing Protocol: Seizure Management Guidelines and Nursing Protocol: Vagus Nerve Stimulator, February 2012.

c. The Post-Sedation Protocol is followed when individuals are administered Diastat or any other sedating medication for prolonged or intractable seizure activity.

9. The Facility urgently needs to ensure that all disciplines responsible for monitoring individuals at high risk for aspiration follow the required Aspiration Trigger Monitoring Guidelines/Instructions. (Provision M.5)
10. The Medication Variance Committee should evaluate and report in the minutes the effectiveness of corrective actions taken for medication variances committed by the respective disciplines responsible for medication administration practices. (Provision M.6)
11.
12. The Nursing Department should ensure that Nurse Managers, at least monthly, complete Medication Room Audits; MAR Audits; Universal Signatures Sheet Audits; and Control Drug Log Audits. (Provision M.6)
13. The Pharmacy should ensure that start and stop date are included on the Medication Administration Record for all medications. (Provision M.6)
14. The Medication Variance Committee should evaluate and report in the minutes the effectiveness of corrective actions taken on medication variances committed by the respective disciplines responsible for medication administration practices. (Provision M.6)
15. The Medication Variance Committee should ensure that all medication variances are counted accurately, and then trended to identify areas for improvement. Medication variances should not only be tracked by the total number of variances, but also tracked by category and by department. This includes all types of Category A medication variances. This includes the specific type of physicians' medication variances, including potential should be included for potential incorrect medications prescribed, incorrect doses, wrong individual, missed allergies, and missed adverse reaction, as well as any other type of medication variance. (Provision M.6)
16. The Nursing Department should ensure that Nurse Managers, at least, monthly complete Medication Room Audits; MAR Audits; Universal Signatures Sheet Audits; and Control Drug Log Audits. (Provision M.6)
17. The Pharmacy should ensure that start and stop date are included on the Mediation Administration Record for all medications. (Provision M.6)

The following are offered as additional suggestions to the Facility:

1. The Facility should enhance its direct care support to prevent decubitus ulcers from developing, and ensure that all individuals who sustain a recurrent lesion, or any decubitus ulcer of stage II or greater, be evaluated by the Facility clinician. (M.1)
2. The Facility should ensure that the respective IDT's QDDP and/or designated staff ensure that other disciplines enter their individuals' clinical assessment data and recommendations for supports and services at least 10 days prior to the individuals' ISP meeting in order for the RN Case Managers to have adequate time to prepare the draft IRRF and IHCP. (Provision M.5)
3. The Facility should continue to consider the risk and benefits of not having medication rooms where individuals could receive medications in privacy and where the nurses administering medication were free from distractions to prevent medication errors/variances. (Provision M.6)

| SECTION N: Pharmacy Services and Safe Medication Practices | |
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| 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:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment 9/24/12<br>2. DSSLC Action Plans 9/24/12<br>3. Presentation Book for Section N<br>4. DSSLC Procedure for Inpatient Medication Dispensing, dated 9/10/12<br>5. DSSLC policy for metabolic syndrome, undated, no policy number<br>6. DSSLC policy for adverse drug reactions, 2/28/12, no policy number<br>7. DSSLC policy for medication variance process, undated, no policy number<br>8. DSSLC policy for drug utilization evaluations, undated, no policy number<br>9. DSSLC policy 053 for medication variance<br>10. DADS state pharmacy policy number 27.1<br>11. Most recent new medications orders, and associated single patient drug interventions (SPDI)<br>12. Ten most recent SPDIs<br>13. QDRR schedule for past 12 months<br>14. Twenty most recent new medication orders, as of October 5 and before<br>15. Two most recent QDRRs, annual physician assessment, most recent ISP, current medication list, last 12 months laboratory results, and last six months of MOSES and DISCUS assessments for individuals #90, #66, #119, #703, #508, #611, #183, #131, and #587<br>16. Pharmacy and Therapeutics Committee (P&TC) minutes for past six months<br>17. Polypharmacy committee minutes for past six months<br>18. Stat chemical restraint debriefing face-to-face form for all chemical restraints administered during past six months<br>19. All adverse drug reaction forms completed in past six months<br>20. Copy of Drug Utilization Evaluation (DUE) schedule for 2012 and 2013<br>21. Copy of all completed DUEs for the past six months<br>22. Medication variance committee report for past six months<br>23. All data, data analysis, and reports for all medication variances for the past six months<br>**People Interviewed:**<br>1. Jana Boone, R.Ph. Pharmacy Director<br>**Meeting Attended/Observations:**<br>1. Pharmacy and therapeutic committee meeting<br>2. Polypharmacy committee meeting |
| | **Facility Self-Assessment:**<br>The Facility assessed itself as being compliant in Provisions N.1 through N.4, and N.6 through N.7 and because the Facility had not ensured that MOSES and DISCUS assessment were completed as necessary, determined itself to be not in compliance with Provision N.5. The Monitoring Team concurs with the Facility's self-assessment of compliance with Provisions N.1, N.4, N.6, and N.7, and with the Facility's |

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| | finding of noncompliance with Provision N.5. The Monitoring Team disagrees with the Facility self-assessment of compliance with Provisions N.2, N.3, and N.8, and determined noncompliance.<br><br>The self-assessment for Provision N.2 focused on the timing, and completion dates of the QDRRs and did not address the comprehensiveness of the QDRRs. The Monitoring Team expects that QDRRs address all medications, efficacy, side effects, and appropriateness of each drug prescribed, in addition to specific documentation of benzodiazepines, anticholinergics, stat chemical restraints, and polypharmacy, as well as provide meaningful clinical recommendations.<br><br>The self-assessment for Provision N.3 did not address the need to provide comprehensive documentation on the QDRRs for stat medications, polypharmacy, benzodiazepines, and anticholinergics, and metabolic syndrome. Also, there was no plan in place to address the efficacy of the QDRR reviews, and recommendations.<br><br>The Facility's self-assessment for Provision N.8, did not adequately address the need to delineate the actual type of medical provider medication variance. Also, there was no process to ensure that action plans for medication variances were assessed for efficacy, or to ensure that appropriate reporting practices of medication variances were in place. |
| | **Summary of Monitor's Assessment:**<br>The pharmacy department continues to progress towards compliance with Provision N, of the Settlement Agreement. The Monitoring Team noted improved processes for reviewing of AEDs, and medication variances. The Monitoring Team also noted continued compliance with Provisions N.1, N.4, N.6, and N7. Full compliance will require addition effort to improve on the QDRR process, ensuring that more robust reporting of AEDs, enhance the medication variance process by focusing more on medical prescribers variances. Overall, the pharmacy department continues to improve on its processes.<br><br>Provision N.1: Review of new medication orders, follow-up documentation by the pharmacist, and the 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.<br><br>Provision N.2: Based on review of the QDRR schedule, the Monitoring Team concluded that the QDRRs were completed timely; however, in two out of six examples (33%), there was no QDRR provided for the reporting period. The Monitoring Team determined that the QDRRs reviewed were not comprehensive, did not fully address laboratory monitoring, did not effectively address polypharmacy, and did not assess efficacy of pharmacological treatment. For these reasons the Monitoring Team determined that the Facility is not in compliance with Provision N2, of the Settlement Agreement.<br><br>Provision N.3: The pharmacy departments appropriately tracked and trended the use of stat chemical |

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| | restraints, polypharmacy, benzodiazepines, and anticholinergic medications. Because the QDDR process did not include a comprehensive assessment of metabolic syndrome, use of polypharmacy, anticholinergic medications, or benzodiazepines, and because metabolic syndrome was not effectively addressed through the QDRR process, the Monitoring Team determined that the Facility is not in compliance with Provision N.3, of the Settlement Agreement. Importantly, all significant issues, including risks and diagnosis of metabolic syndrome, especially when an individual is prescribed an medication that can manifest metabolic syndrome, must be appropriately reviewed by the IDT and reflected in the ISP. It is essential that the pharmacist and psychiatrist address their respective components of the post-chemical restraint clinical review, Face-to-Face document, when reviewing stat chemical restraints.<br><br>Provision N.4: The Monitoring Team noted that physicians had addressed all pharmacy recommendations. When the physician disagreed with the pharmacist's recommendation, the physician's action plan was documented in nine out of nine (100%) examples. The primary care physician and psychiatrist signed, dated, and indicated their agreement with the pharmacist's recommendations in ten out of ten (100%) completed QDRRs. In nine out of ten SPDIs reviewed, the physician provided an action plan, when necessary. Because the physician appropriately responded to pharmacist's recommendations, the Monitoring Team determined that the Facility is in substantial compliance with Provision N.4, of the Settlement Agreement.<br><br>Provision N.5: As reported in Provision J12, there has been an improvement in the timely review of MOSES and DISCUS examinations but there remains a need for better QA monitoring, and a process for change of status evaluations is not yet in place.<br><br>Provision N.6: The Monitoring Team will continue with substantial compliance with Provision N.6; however, the Monitoring Team is concerned with the low number of ADRs reported, and because there were no ADRs reported by direct care staff. The Monitoring Team expects that for subsequent reviews, the Facility will assertively assess the rationale for why direct care staff had not reported ADRs, and for the low number of ADRs being reported.<br><br>Provision N.7: Because the Facility maintained an effective DUE process, the Monitoring Team concluded that continuance of substantial compliance is warranted.<br><br>Provision N.8: The Monitoring Team noted that the pharmacy department maintains a functional process to address medication variances for pharmacists and nursing staff, and that it has made some improvements with incorporating medical services into the medication variances process. Compliance, however, will require that a more comprehensive analysis of medical providers' variances be completed and incorporated into the medication variance meeting minutes. Importantly, meaningful action plans must be developed to address medical providers' medication variances. Also, it is important for all action plans to be evaluated for efficacy. The pharmacy director reported that the Facility is re-evaluating its medication variance process to ensure that medication variances are accurately assessed, and reported. |

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| N1 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature. | To assess compliance with Provision N.1, the Monitoring Team reviewed the Facility's updated procedure for inpatient medication dispensing, interaction summary for the past three months; copy of last ten single patient drug interventions (SPDI) for new medication orders and copy of associated order, and physician response; and copy of the last 20 new medication orders, and any associate SPDI, and related physician communication.<br><br><u>Procedure for Inpatient Medication Dispensing</u><br>The procedure was updated to reflect the Facility's practice of verifying that drug levels were assessed and documented on the WORx drug-lab intelligent alert system. No other changes were noted. The Guideline reflects current pharmacy practice at the Facility.<br><br><u>Interaction Summary</u><br>The Facility maintains a spreadsheet of all identified and reported single patient drug interventions, and includes documentation of physician follow-up on all recommendations made via a SPDI. The Monitoring Team realized the benefit of this tool, which enables a snap shot view of all SPDIs, and follow-up on recommendations<br><br><u>Ten Most Recent Physician Orders for New Medications That required a SPDI</u><br>Review of the most recent ten single patient drug interaction reports (SPDI) revealed that in nine out of ten (90%) examples, the physician appropriately documented, or provided verbal follow-up on SPDI. The Pharmacist provided clear documentation and appropriate notification to physicians of SPDIs in ten out of ten (100%) of the examples.<br><br><u>Twenty Most Recent New Medication Orders</u><br>The most recent 20 scripts written for a new order were reviewed 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.<br><br>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 20 scripts reviewed 20 out of 20 (100%) were labeled correctly; 20 out of 20 (100%) indicated an appropriate diagnosis (100%); 3 out of 3 (100%) which would require lab monitoring had appropriate lab monitoring ordered; and 20 out of 20 (100%) had the pharmacist's initial on the script, indicating that they reviewed the script per procedure. One out of two orders that required blood level monitoring were noted by the pharmacists, and appropriately addressed by the physician. In one out of two orders | Substantial Compliance |

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| | | that required lab monitoring, the pharmacist notified the physician, and was awaiting response.<br><br>Summary:<br>Review of new medication orders, follow-up documentation by the pharmacist, and the 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. | |
| N2 | Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values. | To determine compliance with Provision N.2, the Monitoring Team reviewed the Facility schedule for QDRRs, selected the first five individuals from a list of all individuals known to be provided polypharmacy, and reviewed their annual physician assessment, annual and last quarterly psychiatric assessment, QDRRs, last 12 months of labs and last six months of MOSES and DISCUS assessments.<br><br>QDRR Schedule<br>To determine if QDRRs were current, the Monitoring Team reviewed the Facility's QDRR schedule, and for the first 45 individuals on the schedule, assessed if the QDRRs were completed as required. Of the 45 examples reviewed 44 (98%) examples were completed timely.<br><br>QDRR Review<br>QDRRs were provided for Individuals #66, #90, #119, #703, and #611. The Monitoring Team reviewed these QDRRs, and associated assessments and labs, and noted significant concerns with completion of the QDRRs. For example polypharmacy was not effectively commented on by noting appropriateness, efficacy, and suggesting alternative treatments when clinically appropriate. Laboratory data was not well documented., and efficacy of pharmacologic treatment was not commented on. In one example, the DISCUS assessment was not fully completed by the physician, and the pharmacist did not address this. Although both the psychiatrist and primary physician signed, dated and agreed with the pharmacist's recommendation, there was not physician documentation delineating their action plan.<br><br>Summary:<br>Based on review of the QDRR schedule, the Monitoring Team concluded that the QDRRs were completed timely; however, in two out of six examples (33%), there was no QDRR provided for the reporting period. The Monitoring Team determined that the QDRRs reviewed were not comprehensive, did not fully address laboratory monitoring, did not | Noncompliance |

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| | | effectively address polypharmacy, and did not assess efficacy of pharmacological treatment. For these reasons the Monitoring Team determined that the Facility is not in compliance with Provision N2, of the Settlement Agreement. | |
| 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. | To assess compliance, the Monitoring Team requested copies of the past six months pharmacy and therapeutic committee (P&TC) meeting minutes and polypharmacy committee minutes, completed QDRR forms; annual physician assessments, annual and past six months ISP, past two MOSES and DISCUS assessments, past 12 months of laboratory results, and current medication lists for selected individuals. The pharmacy's ability to assess, and manage metabolic syndrome, polypharmacy, benzodiazepines, stat chemical restraint, and anticholinergic medications, was assessed.<br><br><u>Metabolic Syndrome</u><br>Review of the new policy for metabolic syndrome indicates that body mass index (BMI) can be used in place of abdominal waist circumference. The Monitoring Team disagrees with using BMI as an indicator. The Policy did not clearly delineate all necessary steps the Facility must ensure occurs when assessing for Metabolic Syndrome. For example, when an individual is prescribed a medication that can induce metabolic syndrome, risk factors, such as diabetes, hyperlipidemia, increase in waist circumference, and hypertension, must be clearly documented on the QDRR, and follow-up action must occur, including notification of the IDT, to ensure that the team understands the risks, and is able to make an informed decision on what actions may be necessary. Once metabolic syndrome has been diagnosed, it should be listed on the active problem list.<br><br>From a list of all individuals who were on a neuroleptic and were prescribed medication for either hypertension, diabetes, or hyperlipidemia, the Monitoring Team reviewed the first five individuals on the list by reviewing the past two quarterly drug regimen reviews (QDRR), most recent annual ISP, all addendums to the ISP for the past six months, current medication list, and last 12 months of laboratory data. Of the five cases reviewed for Individuals #119, #183, #131, #587, and #90, zero out of nine (0%) demonstrated a comprehensive review for metabolic syndrome and risk for metabolic syndrome; zero out of five (0%) demonstrate meaningful recommendations to address risk associated with metabolic syndrome while on a neuroleptic; and zero out of five (0%) ISPs documented that the individuals were at additional risk for metabolic syndrome, and its consequence, for individuals with known risk factors for metabolic syndrome, and who are on neuroleptics. The following are some examples demonstrating the Monitoring Teams Concern:<br><br>Individual #131<br>The Individual was prescribed a neuroleptic drug, and had a diagnosis of both diabetes, and hypertension, and the individual's glucose control was worsening. The only | Noncompliance |

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| | | statement on the QDRR was "MS not apparent", and there was no specific recommendation made to address this issue. Importantly, the ISP and medication review form that was approved by human rights did not comment on the potential risk issues associated with the medication, having diabetes, hypertension, and worsening glucose control. The Monitoring Team is well aware that benefits to treatment may outweigh risks; however, the issue must be well documented, and alternative treatments explored by the IDT.<br><br>Individual #119<br>The pharmacist documented that the individual had diabetes, hyperlipidemia, and an enlarged waist circumference and stated "MS criteria met"; however, there was no recommendation made regarding this issue, the ISP did not reflect this serious risk, and the medication review form did not indicate such as risk.<br><br>Individual #90<br>The individual was prescribed two neuroleptics, and had diagnoses of diabetes, hypertension, and hyperlipidemia. The QDRR did not indicate that the individual had metabolic syndrome, and the ISP did not document review of risk versus benefits.<br><br>The Monitoring Team is very concerned with reviews, recommendations, and the management of metabolic syndrome at the Facility.<br><br><u>Benzodiazepines</u><br>The Monitoring Team reviewed the last six months of polypharmacy minutes and P&TC minutes. The Monitoring Team noted that the Facility periodically reviews individuals who were prescribed benzodiazepines, at the polypharmacy meeting, and that each case reviewed was carefully assessed, and when appropriate, provided meaningful recommendations. The Monitoring Team did not find examples whereby the Facility documented a systems review of the use of benzodiazepines, along with a trends analysis. The Monitoring Team believes that the Facility should regularly assess a trends analysis for the use of benzodiazepines.<br><br>As reported by the pharmacy director, the Facility did not specifically address the use of benzodiazepines when conducting a QDRR. The Monitoring Team expects that the use of any scheduled and non-scheduled use of a benzodiazepine be addressed in the QDRR, with clinical recommendations to minimize such use when clinically appropriate.<br><br><u>Polypharmacy</u><br>The Monitoring Team reviewed the past six months of P&TC and polypharmacy meeting minutes. The minutes reflected that individuals were being reviewed on an individual basis, and formal recommendations were being provided, as necessary. The Monitoring | |

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| | | Team noted that there was excellent review of data and trends of the Facility's use of polypharmacy, and that the use of polypharmacy had significantly decreased during the past 12 months. For example, the number of individuals prescribed intra-class medications with high or moderate anticholinergic properties decreased from July 2011, to one in June 2012. The Facility maintains an excellent review of trends for the use of polypharmacy at the Facility.<br><br>Nevertheless, The Clinical Director informed the Monitoring Team that the Facility has as yet to develop and implement an effective mechanism to review polypharmacy, and the Facility's self-assessment indicated that the psychiatrist had not been involved in attendance at meetings designed to establish a polypharmacy review process.<br><br>Review of the most recent QDRRs for Individuals #90, #66, #119, #703, #508, #611, #183, #131, and #587 noted that the administration of polypharmacy therapy was indicated by the pharmacist checking off a check box for polypharmacy, and making a brief comment that the individual was receiving polypharmacy; however, in zero out of nine cases (0%), there were formal recommendations or statement indicating that polypharmacy was effective and necessary, or that alternative therapy should be considered. The Monitoring Team believes that the pharmacist must review the use of polypharmacy for necessity, efficacy, and when necessary, provide recommendations for alternative therapy.<br><br><u>Anticholinergic Medications</u><br>Following review of QDRRs for individuals #90, #66, #119, #703, #508, #611, #183, #131, and #587, there were zero out of nine (0%) where the use of anticholinergic medications were comprehensively assessed by the pharmacists, indicated efficacy, or possible need to consider an alternative medication.<br><br><u>STAT Chemical Restraint</u><br>The Facility reported that no chemical restraint use was reported at the P&TC meetings, and review of the past six months P&TC minutes reflected no stat chemical restraint used; however, subsequent to the most recent P&TC meeting, a STAT chemical restraint was administered to one Individual. The Monitoring Team reviewed the post chemical restraint Face-to-Face report form, and noted that both the physician and pharmacist completed their respective components of the form. The pharmacist did not effectively document the information about maintenance medication; and/or if the behavioral support plan had been changed to reduce the need for chemical restraint; did not document the effectiveness of the chemical restraint; and did not document if any side effects occurred or not as a result of the chemical restraint. The pharmacist did document appropriate utilization of the chemical restraint. The Psychiatrist did not provide a comprehensive review on the face-to-face document by not indicating if side | |

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| | | effects were present or not; did not describe the behavior exacerbation and clinical rationale for administering the chemical restraint; did not document the efficacy of the chemical restraint; and did not provide recommendations to help mitigate the use of chemical restraints in the future.<br><br><u>Summary:</u><br>The pharmacy department appropriately tracked and trended the use of stat chemical restraints, polypharmacy, benzodiazepines, and anticholinergic medications. Because the QDDR process did not include a comprehensive assessment of metabolic syndrome, or of use of polypharmacy, anticholinergic, and benzodiazepines, and because metabolic syndrome was not effectively addressed through the QDRR process, the Monitoring Team determined that the Facility is not in compliance with Provision N.3. Importantly, the IDT must review and appropriately reflect in the ISP all significant issues, including risks and diagnosis of metabolic syndrome, especially when an individual is prescribed a medication that can manifest metabolic syndrome. It is essential that the pharmacist and psychiatrist address their respective components of the post-chemical restraint clinical review, Face-to-Face document, when reviewing stat chemical restraints. | |
| 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. | To assess if physicians appropriately address pharmacy recommendations, the Monitoring Team assessed nine completed QDRRs for ten individuals by selecting the first ten individuals from a list of all individuals who were diagnosed with diabetes (one did not include all requested information), and who were on a neuroleptic, and reviewed the nine most recently completed SPDI reports.<br><br>Review of the most recent nine SPDI reports revealed that in nine out of ten (90%) examples, the physician appropriately documented, or provided verbal follow-up, which was documented by the pharmacist on the SPDI. The Pharmacist provided clear documentation, and appropriate notification to physicians of SPDIs in ten out of ten (100%) of the examples.<br><br>Review of the nine completed QDRRs, which were the sample used for Provision N.3, of Individuals #90, #66, #119, #703, #508, #611, #183, #131, and #587, the Monitoring Team noted that both the primary care physician, and the psychiatrist signed, dated, and accepted the recommendations by the pharmacist in nine, out of nine (100%), samples; hence there were no examples of the physician disagreeing with the pharmacist's recommendation to assess compliance. In addition, there was no specific procedure on physician documentation for pharmacy recommendations.<br><br><u>Summary:</u><br>The Monitoring Team noted that physicians had addressed all pharmacy recommendations. When the physician disagreed with the pharmacist's | Substantial Compliance |

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| | | recommendation, the physician's action plan was documented in nine out of nine (100%) examples; the primary care physician, and psychiatrist signed, dated, and indicated their agreement with the pharmacists recommendations in nine out of nine (100%) recommendations for QDRRs; and in nine out of nine (100%) SPDIs reviewed, the physician provided an action plan, when necessary. Because the physician appropriately responded to pharmacist's recommendations, the Monitoring Team determined that the Facility is in substantial compliance with Provision N.4, of the Settlement Agreement. | |
| N5 | Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia. | The reader is referred to Provision J12 of this report for the Monitoring Team's assessment of the Facility's utilization of side effect scales.<br><br>As reported in Provision J12, there has been an improvement in the timely review of MOSES and DISCUS examinations but there remains a need for better QA monitoring, and a process for change of status evaluations is not yet in place. In the self-rating the Facility acknowledged the need to improve the overall QA effort for tracking completion and review of side effects screening for psychotropic and non-psychotropic medications. The Monitoring Team concurs. | |
| N6 | Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions. | The Monitoring Team noted substantial compliance with Provision N.6 for the past two review periods, and appreciates that the Facility's continued effort to enhance its adverse drug reaction (ADR) reporting process by providing training to all new direct care staff on the ADR process and how to appropriately identify ADRs, and by providing an annual documented in-service to all pharmacists. Importantly, the pharmacy department is developing an on-line training venue that will be provided regularly to all nurses and physicians in the future. During the Monitoring Team's meeting with the director of pharmacy, the issue of possible under-reporting of ADRs was discussed, and it was mutually agreed upon that the Facility may be under reporting ADRs<br><br>All ADRs are reviewed by the pharmacist, who then presents the data to the P&TC for committee review. The Monitoring Team's review of the last six months P&TC meeting minutes reflected the Facility robust documenting, on known and reported ADRs.<br><br>During the past six month period, a total of 12 ADRs were reported. The physician reported four out of the 12 (33%) cases; direct care staff reported zero out of 12 (0%) cases; nursing staff reported two out of 12 (17%); and pharmacists reported six out of 12 (50%).<br><br><u>Summary:</u><br>The Monitoring Team will continue with a rating of substantial compliance with Provision N.6; however, the Monitoring Team is concerned with the low number of ADRs reported. The Monitoring Team expects that for subsequent reviews, the Facility will | Substantial Compliance |

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| | | assertively assess the rationale for why direct care staff had not reported ADRs, and for the low number of ADRs being reported. | |
| N7 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. | The Monitoring Team noted that since gaining substantial compliance for Provision N.7, the Facility continued to ensure that drug utilization evaluations (DUE) were provided for both scheduled DUEs, and on an as needed basis.<br><br>Review of the pharmacy department's schedule for DUEs indicated that during the review period at total of two planed DUEs were initiated, for risperidone, and for Zanaflex, and two unplanned for Imitrex, and for lovastatin, which were conducted secondary to FDA advisories.<br><br>Review of the P&TC minutes for the past six months indicated that DUE data and clinically relevant information was communicated to physician staff. Importantly, the pharmacy also followed up on DUEs to ensure that their recommendations were followed.<br><br>The Monitoring Team noted that the FDA issued an advisory on Celexa on 3/28/12; however, the Facility did not initiate a DUE for this important advisory. Following discussion with the pharmacy director, it was explained that the pharmacy department misunderstood the FDA advisory, and believed that they had already completed in DUE in the past. Following closer review, the pharmacy director recognized that additional information was issued by the FDA, and will immediately initiate a DUE for the FDA advisory of 3/28/12.<br><br><u>Summary:</u><br>Because the Facility maintained an effective DUE process, the Monitoring Team concluded that continence of substantial compliance is warranted. | Substantial Compliance |
| N8 | Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances. | To assess the Facility's medication variance process, the Monitoring Team requested all medication variance committee meeting minutes, and associated data, trends analysis, and updates to the medication variance policy and pharmacy policy.<br><br>At the last compliance review, the Monitoring Team noted that the Facility developed and implemented an excellent process for tracking, trending, analyzing, and rectifying system and personnel issues related to medication variances. The two outstanding issues noted at the time of the last review were that there was a lack of the medical department's participation in the medication variance process, and a lack of follow-up and assessment of effect of medication variance corrective action plans. | Noncompliance |

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| | | Following review of the medication variance committee meeting minutes, and associated data and analysis, the Monitoring Team noted that the minutes reflected comprehensive review of medication variances for nursing and for pharmacy staff, and also noted that the minutes reflected that the medical director attended both meetings; however, physician medication variances were not described as detailed, as were nursing and pharmacy staff variances. Furthermore, physician variances were not counted in the total medication variances. The medication variance committee meeting minutes indicated that medical providers were responsible for 61 potential medication variances, and one actual medication variance in July; however, the data did not adequately reflect the type of medication variance, other then documentation. Medical providers' variance should be broken down to reflect actual type of variance to permit evaluation and improvement as needed. For example, a physician variance could be secondary to writing a prescription for the wrong individual, the wrong dose, or a non-approved indication. Also of concern to the Monitoring Team was that three medical providers were responsible for a significant number of potential medication variances; for example, Provider #7 was noted to have three variances in June and 18 in July, and Provider #9 was responsible for seven variances in June and 8 in July. This information was not clearly delineated in the minutes, and there was no action plan initiated to address the medication variances.<br><br>As reported in Provision M6, since the last compliance review, the Chief Pharmacist and CNE had worked with the Data Analyst to clarify some disparity found in the data. During the Committee's review of medication variance data, it was identified that while the pharmacy reported all dispensing/order entry medication variances (Category A, variances that did not reach the individual), these variances were reported into a separate database and were not included in the overall medication variance counts along with the nurses' variance. The Facility identified this disparity and was taking action to correct it.<br><br>The Monitoring Team did not find evidence to support that the Facility maintains a process to assess the efficacy of action plans for systems and staff related medication variance issues. The Monitoring Team expects the Facility to periodically assess all actions plans for completion and efficacy.<br><br>Based on the significant number of medications being prescribed, dispensed and administered by the Facility, the Monitoring Team has significant concerns with the total number of medication variances being reported. For example, in August there were a reported total of 283,470 doses of medication administered, and there were only 36 actual medication variances reported by the medication variance committee, which is an effective medication variance rate of 0.127 per 1000 doses of drugs administered. | |

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| | | Comparatively, the rate of medication errors reported by the National Institute of Health that occurred at an in-patient hospital facility was 111.4 errors per 1000 doses administered. This suggests to the Monitoring Team that the Facility may be under-reporting medication variances.<br><br>Summary<br>The Monitoring Team noted that the pharmacy department maintains a functional process to address medication variances for pharmacists and nursing staff, and that it has made some improvements with incorporating medical services into the medication variances process. Compliance, however, will require that a more comprehensive analysis of medical providers variances be completed, and incorporated into the medication variance meeting minutes. Meaningful action plans must be developed to address medical providers' medication variances. Also, it is important for all action plans to be evaluated for efficacy. The Monitoring Team was pleased to learn that the Facility was planning to evaluate its medication variance reporting process, and determine if the Facility is appropriately reporting medication variances. | |

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

1. The clinical pharmacist must ensure that benzodiazepines, anticholinergics, polypharmacy, metabolic syndrome, and chemical restraints are clearly and comprehensively addressed on the QDRR, and meaningful recommendations are provided when clinically necessary. (Provisions N.2, and N.3)
2. The clinical pharmacists must ensure that QDRRs reflect a comprehensive review of the individual's drug regimen, which includes a review of efficacy, side effects, documentation of all laboratory and other diagnostic result, as necessary to assess prescribed medications. (Provision N.3)
3. The Pharmacist must ensure that the team is made aware of all adverse outcomes and potential significant adverse outcomes related to the individual's medications. (Provision N.3)
4. The pharmacist and psychiatrist must comprehensively document a review of all chemical restraint use on the post-chemical restraint clinical review Face-to-Face form. This must include a review of the scheduled psychotropic medications and possible need to change the medication and/or dose, effectiveness of the chemical restraint, observed side-effects, and other pharmacological and non-pharmacological alternatives to the future use of chemical restraints. (Provision N.3)
5. The Facility must assess the reporting process for ADRs, and ensure that it is appropriately identifying and reporting potential ADRs; in particular, there should be review to determine if direct support professionals are reporting to nurses (as required by DSSLC policy) all changes in individuals' appearance, behavior, or other signs that could lead to identification of ADRs. (Provision N.6)
6. The Facility must ensure that it identifies, and reports all medication variances. (Provision N.8)
7. The medication variance process must better reflect medical providers' medication variances. For example, medication variances should be broken down into more specific categories, such as incorrect dose, incorrect indication, or wrong patient.
8. Action plans for medication variances should be assessed for efficacy. (Provision N.8)
9. Ensure that QDRRs are completed per standard of care practice, such as standards delineated by the Centers for Medicare and Medicaid Services (CMS), guideline on Medication Regimen Reviews (http://www.aging.pitt.edu/professionals/resources/S&C-06-29-11-F428MedRegReviewInstructorGuide.pdf). (Provision N.2)

| SECTION O: Minimum Common Elements of Physical and Nutritional Management | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Self Assessment 9/24/2012<br>2. DSSLC Action Plan 9/24/12<br>3. Presentation Book for Section I, Section O, and Section P<br>4. DSSLC Physical and Nutritional Management Policy 012.2 (revised 10/2012)<br>5. Record reviews:<br>a. Sample 1: Individuals #13, #35, #37, #441, #499, #503 and #750<br>b. Sample 2: Individuals #105, #134, #243, #279, #373, #432, #466, and #715<br>c. Sample 3: Individuals #273, and #296<br>d. Sample 4: Individuals #3, #24, #85, #92, #136, #164, #206, #323, #507, and #743<br>6. A list of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management team (PNMT) members, including credentials<br>7. A list of continuing education sessions or activities participated in by PNMT members since last review (4/2012)<br>8. Minutes, including documentation of attendance, for the PNMT and Physical and Nutritional Management Committee (PNMC) meetings for the past 6 months<br>9. Individual PNMT reports as available for individuals reviewed above<br>10. A list of PNM assessments and updates completed in the last quarter<br>11. Individual Support Plans (ISPs) for all sample individuals<br>12. Completed Physical Nutritional Management Plans (PNMPs) for all sample individuals<br>13. Tools used to monitor implementation of PNM procedures and plans<br>14. A list of individuals for whom PNM monitoring tools were completed in the last quarter<br>15. Tools utilized for validation of PNM monitoring<br>16. For the past two quarters, any data or trend summaries used by the Facility related to PNM, and/or related quality assurance/enhancements reports, including subsequent corrective action plans<br>17. PNMP template and any instructions for use of template<br>18. PNM spreadsheets generated by the Facility<br>19. Lists of individuals:<br>a. On modified diets/thickened liquids;<br>b. With BMI equal to greater than 30;<br>c. With BMI equal to less than 20;<br>d. Since March 2011, who have had unplanned weight loss of 10% or greater over six (6) months;<br>e. During the past six months, have had a choking incident;<br>f. During the past six months, have had a pneumonia incident;<br>g. During the past six months, have had skin breakdown;<br>h. During the past six months, have had a fall; |

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| | i. During the past six months, have had a fecal impaction;<br>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.);<br>k. With poor oral hygiene; and<br>l. Who receive nutrition through non-oral methods<br>20. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation since the last review<br>21. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials<br>22. Tools and checklists used to provide competency-based training addressing:<br>a. Foundational skills in PNM; and<br>b. Individual PNM and Dining Plans<br>23. Physical and Nutritional Management Related Training Data<br>**People Interviewed:**<br>1. Donna Groves OTR Director of Habilitation Therapies<br>2. Staci Kraus RN-PNMT RN<br>3. Paula Horn PT<br>4. Cecilia Payne COTA PNMP Coordinator<br>5. Erin O'Toole SLP<br>6. Eight DCPs (Houston Park, Cedar Falls, Eastfield, Westridge, and Garden Ridge)<br>**Meeting Attended/Observations:**<br>1. Physical and Nutritional Management Team 10/9/12<br>2. Mealtimes and Transitions- Houston Park, Cedar Falls, Garden Ridge, and Eastfield |
| | **Facility Self-Assessment:**<br>DSSLC's Self-Assessment, updated 9/24/12, 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.<br><br>For the self-assessment, the Facility described, for each provision item, the activities it 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. Missing from the Self Assessment was the method for obtaining their sample.<br><br>The Action Plan updated 9/24/12 identified the action steps that DSSLC was involved in to potentially reach compliance. The steps were clear and provided information regarding the projected completion date as well as current status. Use of this format should assist DSSLC in better being able to identify their current status and the future areas that still require attention and improvement. |
| | **Summary of Monitor's Assessment:**<br>Many positives were noted within this provision. DSSLC continued to take steps forward with regards to |

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| | the providing of Physical Nutritional Management (PNM) Services. The PNMT continued to show adequate review of individuals on caseload but many times individuals who were having issues or had a significant history of PNM issues were not consistently provided the needed assessment or thorough review. PNMPs were noted to have become more comprehensive than previous reviews but were still lacking the comprehensiveness as it related to oral hygiene and care. Staff implementation of PNMPs, while improved, remained highly inconsistent with an implementation rate below 50% resulting in unnecessary risk being placed upon the individuals residing at DSSLC. Staff knowledge of plans was also noted to improve but remained below the level needed to master the plans in which they were responsible. New Employee training was comprehensive but DSSLC lacked the needed annual or refresher trainings needed for staff knowledge to remain at a high level. In addition, other ongoing training training was not provided in a manner that ensured all staff responsible for implementing individualized plans was provided with the needed training prior to working with the individual.<br><br>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 focus more on observing all of these policies being implemented at the level of care. This remains an area that was pervasively lacking.<br><br>**Provision O.1:** This provision was determined to be not in compliance. A Physical and Nutritional Management Team (PNMT) was in place 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.<br><br>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.<br><br>Since the last compliance review, DSSLC had revised 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. Also included in the policy was the criterion that guided the PNMT in establishing level of PNMT support.<br><br>PNMPs were not in alignment with current best practice standards. For issues related to this component, please refer to Provision O.3<br><br>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.<br><br>**Provision O.2:** Individuals were not provided with comprehensive assessments in response to changes in |

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| | status or as part of an annual assessment. Individuals who had a significant history of PNM issues were not consistently identified and provided with the needed assessments. On a positive note, when individuals were identified as needing assessments, the assessments were comprehensively provided by the PNMT. Supports regarding the areas of oral care were not comprehensively included in the PNMP.<br><br>**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 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.<br><br>**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 or positioning strategies. Per interview, staff again was not knowledgeable of the plans and why the proposed strategies were relevant to the individuals' well being.<br><br>**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.<br><br>**Provision O.6:** This provision was determined to be not in compliance. DSSLC was lacking a consistent method to ensure inter-rater reliability. Monitors were 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.<br><br>**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.<br><br>**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 issues 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. |

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| O1 | Commencing within six months of the Effective Date hereof and with full implementation within two | Due to the multiple requirements included in this provision of the Settlement Agreement, as well as the requirements of this overarching provision of the Settlement Agreement being further detailed in other components of Section O, the following summarizes the | Noncompliance |

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| | years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, 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 | review of the requirements related to the PNMT, including the composition of the team, the qualifications of team members, and the operation of the team.<br><br>DSSLC has two teams/committees that focus on Physical and Nutritional Management issues--the 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 and campus issues.<br><br>The Physical and Nutritional Management Committee (PNMC), whose primary role was to look at systems issues, consisted the following members:<br>• Stephen Kubala MD-Medical Director<br>• Donna Groves OTR-Director of Habilitation Therapy<br>• Delia Schilder RN-Chief Nurse Executive<br>• Dora Tillis-Assistant Director of Program Services (ADOP)<br>• Nancy Condon-Facility Director<br>• Sherri Courtney Nurse Operations Officer<br>• Sibylle Graviett Nurse Case Manager Supervisor<br>• Lori Powell QA Director<br>• Jean Mykietyn, PNMT Occupational Therapist<br><br>Other members attended as requested or for special clinical specialty as needed, 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.<br><br>Per review of the PNMC minutes from 5/2012 to 9/2012 there was evidence that the PNMC reviewed systemic issues at DSSLC. Among the issues discussed included:<br>• Fall prevention<br>• Occurrence of pneumonia<br>• Other issues related to dysphagia, oral hygiene, skin integrity and catheter use.<br><br>PNMC attendance was satisfactory as all members of the PNMC had an attendance record of greater than 80%.<br><br>The PNMC in collaboration with the QA department had developed clinical indicators that assisted DSSLC in establishing facility systemic trends. Among the clinical indicators reviewed by the PNMC on a monthly basis was:<br>• Hospitalizations | |

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| | demonstrating competence in working with individuals with complex physical and nutritional management needs. | • ER visits<br>• Deaths<br>• Skin Integrity<br>• Enteral Nutrition<br>• Aspiration Pneumonia<br>• Pneumonia<br>• Falls<br>• Diabetes Management Report<br>• Individuals followed by PNMT and the PNMT's level of involvement<br>• UTIs<br>• Pseudomonas<br><br>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.<br><br>The Physical and Nutritional Management Team (PNMT), which focused on clinical issues, consisted of:<br>• Staci Kraus-RN-PNMT RN<br>• Melisa Vujouich-Brown RD<br>• Paula Horn PT<br>• Cecilia Payne PNMP Coordinator<br>• Erin O'Toole SLP<br>• Jean Mykietyn OTR<br><br>PNM Team attendance records for 21 meetings from 7/1/12 to 9/12/12 documented inconsistent attendance by PNM Team standing members. Attendance for the PNMT were as follows:<br>• Staci Kraus-RN-PNMT RN attended 18 of 21 meetings (85%)<br>• Melisa Vujouich-Brown RD attended 11 of 21 meetings (52%)<br>• Paula Horn PT attended 15 of 21 meetings (71%)<br>• Cecilia Payne PNMP Coordinator attended 14 of 21 meetings (66%)<br>• Erin O'Toole SLP attended 20 of 21 meetings (95%)<br>• Jean Mykietyn OTR attended 18 of 21 meetings (85%)<br><br>The makeup of the PNMT was in compliance with standards set forth by the Settlement Agreement as DSSLC had added a full time dedicated PNMT Speech Pathologist. The issue was lack of consistent participation by the standing members. Failure to have all | |

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| | | members present decreased the likelihood of a comprehensive discussion of the PNM related event.<br><br>While DSSLC did have a list of back-up PNMT members that included the RN Supervisor, multiple dietitians, and the Habilitation Therapy (HT) director; they did not clarify in policy what disciplines or positions they were intended to back up. There was also not a back up Physical Therapist or Speech Therapist identified.<br><br>PNMT minutes demonstrated evidence of PNM discussion but at times were difficult to follow due to clarity issues surrounding whether or not action plans were completed.<br><br>Reports continued to supplement the meeting minutes and provide more detailed information regarding analysis and assessment of the individuals seen by the PNMT.<br><br>Review of documentation of PNM clinical instruction submitted by the Facility for the dates of April 1, 2012 to September 13, 2012 revealed opportunities for PNMT members to participate in trainings relevant to increasing their knowledge of PNM. The courses attended by some members focused on:<br>• Enhanced Risk and Integrated Health Care Plan Training<br>• Swallow Safety<br>• Allied Orthotics<br>• Nutritional Supports<br><br>PNMT meetings were held a minimum of weekly with many times occurring twice weekly. As stated previously, there were 21 meetings that occurred between 7/1/2012 and 9/12/2012.<br><br>Since the last compliance review, DSSLC had revised a localized PNMT policy that defined the roles and responsibilities of the PNMT and the collaboration that was intended to occur with the IDT. The policy was comprehensive and provided clear direction regarding the PNM referral process, implementation of the Physical and Nutritional Management Plan (PNMP), and PNM Quality Assurance components. 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. Also included in the policy was the criterion that guided the PNMT in establishing level of PNMT support.<br><br>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.<br><br>Per review of eight individuals diagnosed with pneumonia and/or choking; Eight of eight | |

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| | | (100%) were discussed at the PNMT or Interdisciplinary Team (IDT) meeting but a concern by the Monitoring Team was that all individuals who were in need of a comprehensive PNMT evaluation were not consistently provided with one. Out of the six individuals who were diagnosed with pneumonia, only two were provided with a comprehensive assessment by the PNMT. Examples included:<br>• Individual #715, #466, and #243 had been diagnosed with pneumonia 12, 8, and four, times respectively over the past three years but were not provided with a comprehensive PNMT evaluation. | |
| 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 seven individuals who were chosen from a list provided by DSSLC of individuals they identified as being at a high risk of aspiration. The sample accounted for 11% of those identified by DSSLC as being at high risk for aspiration.<br><br>Sample #2 was chosen from the list of individuals provided by DSSLC who were diagnosed with an aspiration and/or choking event over the past 6 months. The sample consisted of two individuals who accounted for 40% of the individuals who experienced a choking event and seven individuals who accounted for 77% of the individuals who experienced an aspiration event.<br><br>Sample #3 consisted of two individuals who accounted for 100% of new admissions since the previous compliance review.<br><br>Based on a review of individuals' PNMT assessments that were completed (Sample #2), two of two (100%) individuals who were provided with a comprehensive assessment had an assessment 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.<br><br>A primary role of the PNMT RN was to assess all individuals who returned from the hospital with a PNM related issues (i.e., aspiration, choking). The PNMT RN's responsibility was to alert the PNMT or Habilitation Therapists of individual cases of aspiration pneumonia and changes in health status that were pertinent to the PNMT and/or Habilitation Therapists.<br><br>The PNMT nurse assessed six of the six (100%) individuals in Sample #1 who returned from the hospital, and all eight individuals from Sample #1 (100%) were discussed at the PNMT meeting. 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. | Noncompliance |

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| | | A comprehensive PNMT evaluation was completed by the PNMT as based on referral by the IDT. Components of this assessment included:<br>• Reason for Referral<br>• Risk Level<br>• Prior Hospitalizations<br>• Nutritional Indicators<br>• Physical Clinical Indicators<br>• Diagnostic Consultations and Tests<br>• Medical Treatments<br>• Medication Side Effects<br>• Supportive Care<br>• Summary/Analysis<br>• Recommendations<br><br>Over the past two months, five PNMT evaluations had been completed. Based on review of the completed evaluations, all (100%) were noted to contain the above components as indicated and represented a comprehensive review and assessment of the individual's status.<br><br>Based on a review of eight (Sample #2) records of individuals who experienced an aspiration or choking event, eight of eight (100%) records reviewed accurately identified individuals as being at a high risk as evidenced through review of the Integrated Risk Ratings Forms. This was a significant improvement as the previous compliance visit noted only 45% accuracy with PNM related risk ratings.<br><br>Per review of eight individuals diagnosed with pneumonia and/or choking; Eight of eight (100%) were discussed at the PNMT or Interdisciplinary Team (IDT) meeting but a concern by the Monitoring Team was that all individuals who were in need of a comprehensive PNMT evaluation were not consistently provided with one. Out of the six individuals who were diagnosed with pneumonia, only two (33%) were provided with a comprehensive assessment by the PNMT. Examples included:<br>• Individual #715, #466, and #243 had been diagnosed with pneumonia 12, 8, 4, times respectively over the past 3 years but was not provided with a comprehensive PNMT evaluation. | |
| O3 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain | All persons identified as requiring PNM supports were provided with a Physical and Nutritional Management Plan (PNMP); however, the plans were not consistently comprehensive as many times they contained vague and general information regarding oral care and at times did not contain PNM related triggers. | Noncompliance |

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| | 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. | Based on a review of 18 individual PNMPs (Samples #1, #2, and #3), individuals were not provided with a comprehensive PNMP.<br>• In ten of 18 PNMPs reviewed (55%), comprehensive strategies for oral hygiene were included.<br>• In 5 of 18 PNMPs (27%) reviewed, comprehensive strategies for medication administration were included. While this component has shown much improvement, the detail regarding safety or tolerance of pill intake was missing from the PNMP.<br><br>Review of the format suggests the triggers that were 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). Per the HT director, the trigger sheet process was being revised and part of the revised process will be to further individualize triggers not only on the PNMP but on the trigger sheets as well. This process had not begun at the time of this review and therefore will need to be monitored at the next compliance visit.<br><br>An improvement noted with the PNMP was the inclusion of the degree of head of bed elevation. This is important as it allowed 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.<br><br>There were several positive practices that the Facility should ensure continue.<br>• In 18 of 18 PNMPs (100%) reviewed, positioning instructions for wheelchair and alternate positions instructions were included as applicable.<br>• In 18 of 18 PNMPs (100%) reviewed, transfer instructions were included as applicable.<br>• In 18 of 18 PNMPs (100%) reviewed, the mealtime/dining plan included intake information for mealtime and snacks<br>• In 18 of 18 PNMPs (100%) reviewed, the mealtime/dining plan included food/fluid textures as applicable.<br>• In 18 of 18 PNMPs (100%) reviewed, the mealtime/dining plan included behavioral concerns related to intake.<br>• In 18 of 18 PNMPs (100%) reviewed, individual adaptive equipment for mealtime was included.<br>• In 18 of 18 PNMPs (100%) reviewed bathing/showering positioning and instructions were included | |

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| | | • In 16 of 18 PNMPs reviewed (88%), PNM triggers to be observed and reported were listed as part of the plan. This was an improvement of 88% since the last compliance review.<br><br>Based on a review of an identified sample of 18 individual records (Samples #1, #2, and #3) PNMPs and dining plans were not formally developed with input from the IDT. In five of 18 records reviewed (27%), 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. | |
| O4 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties. | 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 not consistent evidence of discussion of the PNMP and how it was positively or negatively impacting the person's life.<br><br>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.<br><br>Staff did not consistently implement interventions and recommendations outlined in the PNMP and/or Dining Plan.<br><br>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:<br>• In eight of 19 (42%) observations, staff were following mealtime plans.<br>• In 11 of 23 (47%) observations staff were following positioning instructions.<br><br>Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan included:<br>• Individual #94 was not provided with cues to take small bites and sips, or swallow between bites thus increasing the risk of choking.<br>• Individual #153 was eating at an unsafe rate with no cues to slow down.<br>• Individual #381 was observed slid down in chair with a posterior pelvic tilt resulting in increased pressure to the buttocks thus increasing the risk of a pressure sore.<br>• General safe mealtime practices such as providing liquids during the meal and | Noncompliance |

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| | | encouragement to eat at a slow pace were also not observed.<br><br>Overall, there was approximately 10% improvement since the last compliance visit with regards to ensuring individuals is provided services in accordance with the PNMP.<br><br>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:<br>• Individual #441 was observed in supine position when the plan called for him to be in right side lying.<br>• Individual #66 was still in bed when the plan called for him to be in his wheelchair.<br>• Individual #218 was observed slid down in bed when the plan called for him to be elevated.<br>• 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.<br><br>Staff did not consistently understand rationale of recommendations and interventions as evidenced by not verbalizing reasons for strategies outlined in the PNMP. Lack of understanding regarding why an intervention was important contributes to a lack of urgency regarding implementation. Based on interviews with eight DCPs, responses to questions about PNMPs were:<br>• Where is the PNMP/Dining Plan located? (100% answered correctly)<br>• What kind of transfer do they require? (100%)<br>• What do you look for to ensure the individual is in the correct position? (50%)<br>• Why does the individual need thickened liquids? (62%)<br>• Why does individual eat modified texture foods? (75%)<br>• Why does the individual require a specific utensil? (50%)<br>• Why does the individual require a specific assistance technique? (25%)<br>• What are the individual's risk indicators? What do you look for before, during and after the meal? (50%)<br>• Does the individual have an Aspiration Trigger Data Sheet, where is it kept and when do you document? (50%)<br>• Have you been trained to implement this plan? (75%)<br>• Who do you contact if you have difficulty with the plan or the equipment? (90%)<br><br>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 | |

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| | | may not observe for and report related health concerns or ensure their actions do not contribute to these risks. While there is still much work to be done to improve overall staff knowledge regarding PNM. Staff knowledge has been maintained or improved by 10% or greater in all categories. | |
| 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. As of this review, percentage of staff trained on basic PNM related issues included:<br>• Lifting People (98%)<br>• Physical Management (100%)<br>• Preventing Aspiration Pneumonia (97%)<br>• Personal Care Services (99%)<br><br>Review of the Facility's training curricula revealed that it did include PNM training in the following areas:<br>• Aspiration Pneumonia<br>• PNMP philosophy<br>• Techniques and equipment for individuals served<br>• Lifting and Transfer<br>• Positioning<br>• Dining/eating/oral intake<br>• Monitoring Individuals for PNM issues<br><br>These topics were imbedded into the following training classes:<br>• Lifting People<br>• Preventing Aspiration Pneumonia<br>• Physical Management Skills<br>• Personal Care Services<br><br>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 People", "CPR" and "Preventing Aspiration Pneumonia". Missing from the annual trainings were Physical Management Skills and Personal Care Services.<br><br>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 | Noncompliance |

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| | | 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. | A policy/protocol that addressed the monitoring process and provided 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.<br><br>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. A concern was that the monitoring forms contained a section labeled compliance and noncompliance. Compliance was achieved with a score of 80% or higher. The problem was that each question was weighted equally resulting in staff being observed not implementing the plan but still being scored high enough to be rated as in compliance.<br><br>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 the data aggregated by areas addressed by the PNM monitoring form. There was no system in place that allowed for the overall tracking and trending of the monitoring data. A system did accumulate the data but did not provide information regarding the difference between effectiveness of the plans and staff implementation of the plans.<br><br>Per review of the monitoring list provided by DSSLC, 361 individuals had been provided with PNM monitoring. Out of the 361 monitoring forms completed:<br>• 4 of 361 (1%) focused on bathing<br>• 30 of 361 (8%) focused on communication<br>• 14 of 361 (4%)focused on lifting and transfers<br>• 109 of 361 (30%) focused on mealtime and/or snacks<br>• 74 of 361 (20%) focused on medication administration<br>• 9 of 361 (2%) focused on oral care<br>• 121 of 361 (33%) focused on positioning<br><br>There was a 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.<br><br>In addition to the standard effectiveness monitoring schedule, monitoring was provided in two ways: | Noncompliance |

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| | | • The risk process included a monitoring component where the IDT and/or PNMT determined through an action plan/discussion specific areas of needed monitoring. This type of monitoring was more specific to an issue at hand (i.e., bed positioning)<br>• General monitoring that focused on mealtime standards was provided by non-clinical staff.<br><br>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.<br><br>DSSLC was lacking a consistent method to ensure inter-rater reliability. Monitors were 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 18 individual records (Samples #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.<br><br>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).<br><br>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.<br><br>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 | Noncompliance |

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| | | monitor the presence or absence of triggers related to potential aspiration. Per the HT director, a new process is about to be implemented that will place the determination of whether the individual requires a trigger sheet on the IDT. As stated, this process had not begun so further review will be needed at subsequent visits.<br><br>The trigger sheet is a valuable asset in better being able to identify signs and symptoms. As such, DSSLC must ensure that by switching processes, individuals who would benefit from the acquired data are not denied the service.<br><br>Issues noted with the existing data sheet and process included:<br>• Lack of individualized triggers.<br>• Lack of consistent and detailed documentation surrounding the occurrence of triggers (e.g., activity in which trigger occurred, positioning of the individual).<br>• Lack of consistent completion by staff (missing data points).<br>• Lack of review by the appropriate nursing personnel | |
| O8 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding. | The following section was based on a sample gathered from individuals who received enteral nutrition (Sample 4). Ten of these individuals were included in the sample reviewed by the Monitoring Team. There were 89 individuals listed as receiving enteral nutrition.<br>All individuals who received non-oral intake (NPO) in the selected sample had been provided a PNMP that included the same elements described above.<br><br>The Aspiration Pneumonia/Enteral Nutrition Evaluation (APEN) was to be used for all individuals who were at high risk for aspiration pneumonia or who were hospitalized for aspiration pneumonia, 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. Per the HT director, the APEN was placed in the shared drive to allow all professionals the ability to enter their specific information for discussion either at the ISP, ISPA, or PNMT.<br><br>Based on the sample of ten individuals (sample 4), ten of ten (100%) individuals had received the interdisciplinary enteral nutrition assessment provided by the State, but content within these evaluations was inconsistent and variable. While all the evaluations included why the tube was medically necessary, none of the evaluations 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. | Noncompliance |

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| | | 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.<br><br>Based on a review of ten individuals' ISPs, for zero of ten (0 %) (Sample #4) who received enteral nutrition, the individual's ISP clearly documented the rationale for the continued need for enteral nutrition. | |

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

1. The Wound Care Nurse should be listed as a permanent member of the PNMC (Provision O.1)
2. Medication administration and Oral Care should be expanded to include information regarding number of pills the individual can tolerate at a time, and strategies to assist with oral care. (Provision O.3)
3. 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).
4. 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)
5. Aspiration Trigger Data Sheet should be modified to include triggers specific to the individual (Provision O.7).
6. 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 and or improved overall oral functioning (Provision O.8)
7. 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)
8. 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)

| SECTION P: Physical and Occupational Therapy | |
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| 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:**<br>**Documents Reviewed:**<br>1. DSSLC Self Assessment 9/24/2012<br>2. DSSLC Action Plan 9/24/12<br>3. Presentation Book for Section I, Section O, and Section P<br>4. DSSLC Physical and Nutritional Management Policy 012.2 (revised 10/2012)<br>5. Record reviews:<br>• Sample 1: Individuals #13, #35, #37, #441, #499, #503 and #750<br>• Sample 2: Individuals #105, #134, #243, #279, #373, #432, #466, and #715<br>• Sample 3: Individuals #273, and #296<br>• Sample 4: Individuals #196, #209, #404, #580, and #611<br>6. A list of all therapy and/or clinical staff—occupational therapists (OT), physical therapists (PT), speech and language pathologists (SLP), dietitians (RD), and Physical and Nutritional Management team (PNMT) members, including credentials<br>7. A list of continuing education sessions or activities participated in by PNMT members since last review (4/2012)<br>8. Current Lists of people:<br>(a) Who use wheelchair as primary mobility;<br>(b) With transport wheelchairs;<br>(c) With other ambulation assistive devices, including the name of the device;<br>(d) With orthotics and/or braces;<br>(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;<br>(f) Who have experienced a falling incident during the past three (3) months, including name of individual, date, location, whether there was injury, and, if so, type of injury.<br>8. PNM maintenance Logs (January 2012-present)<br>9. OT/PT assessments template<br>10. Wheelchair seating, PNM clinic assessment templates<br>11. For the past 12 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.<br>12. List of individuals receiving direct OT and/or PT services and focus of intervention.<br>**People Interviewed:**<br>1. Donna Groves OTR Director of Habilitation Therapies<br>2. Paula Horn PT<br>3. Cecilia Payne COTA PNMP Coordinator<br>4. Eight DCPs (Houston Park, Cedar Falls, Eastfield, Westridge, and Garden Ridge)<br>**Meeting Attended/Observations:**<br>1. Physical and Nutritional Management Team 10/9/12<br>2. Mealtimes and Transitions- Houston Park, Cedar Falls, Garden Ridge, and Eastfield |

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| | **Facility Self-Assessment:**<br>DSSLC's Self-Assessment, updated 9/24/12, 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.<br><br>For the self-assessment, the Facility described, for each provision item, the activities it 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. Missing from the Self Assessment was the method for obtaining their sample.<br><br>The Action Plan updated 9/24/12 identified the action steps that DSSLC was involved in to potentially reach compliance. The steps were clear and provided information regarding the projected completion date as well as current status. Use of this format should assist DSSLC in better being able to identify their current status and the future areas that still require attention and improvement.<br><br>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 moving forward, as will using the data to identify areas in which focused attention is needed. |
| | **Summary of Monitor's Assessment:**<br>DSSLC continued to show overall improvement with services identified within this provision. DSSLC had just recently implemented a new annual assessment format titled "Assessment of Current Status" in which the intent behind the new form was to provide more evidence of clinical assessment and review of identified areas of need over the past year. The Monitoring Team is hopeful that this new format will address the primary concern with the existing assessments in that they lacked comparative analysis of status and clear information regarding factors for community placement.<br><br>An area of improvement was DSSLC's effort in responding to falls. The team has continued to respond more frequently and in a more comprehensive manner, especially over the last two reviews. While the response and comprehensiveness had improved, information obtained through these assessments as well as others was not integrated as part of the ISP in a way that was meaningful and functional to the individual. As stated in Provision O, lack of plan implementation continued to be a pervasive issue.<br><br>**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:<br>• There was no discussion of potential for skill acquisition in areas such as eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning.<br>• In the cases in which therapy supports had been provided, there was no assessment as to the effectiveness of the interventions. |

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| | • There was no comparative analysis of health and functional status from the previous year.<br><br>**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 ISP.<br><br>**Provision P.3:** This provision was determined to be not in compliance. Plans were not implemented as written and staff were not knowledgeable of the OT/PT plans.<br><br>**Provision P.4:** This provision was determined to be not in compliance. A system did not exist that ensures staff responsible for positioning and transferring high risk individuals receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff. |

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| P1 | By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the 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. | Sample #1 consisted of seven individuals who were chosen from a list provided by DSSLC of individuals they identified as being at a high risk of aspiration. The sample accounted for 11% of those identified by DSSLC as being at "high" risk for aspiration<br><br>Sample #2 was chosen from the list of individuals provided by DSSLC who were diagnosed with an aspiration and/or choking event over the past 6 months. The sample consisted of two individuals who accounted for 40% of the individuals who experienced a choking event and seven individuals who accounted for 77% of the individuals who experienced an aspiration event.<br><br>Sample #3 consisted of two individuals who accounted for 100% of new admissions since the previous compliance review.<br><br>Sample#4 consisted of five individuals who experienced the highest number of falls over the past 6 months.<br><br>At the time of this review, the census at DSSLC was 492 individuals. The reported number of individuals with PNM needs was 427 or 87% of the total census. The assistants were not licensed to complete assessments and design interventions supports and, as such, were not included in ratio calculations to determine adequacy of staffing. Their roles were critical, however, in that they were to provide training, supervision of technicians and Physical and Nutritional Management Plan Coordinators (PNMPCs), assist with data gathering, provide monitoring, and provide other indirect supports. | Noncompliance |

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| | | The Facility provided an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience. There were seven Occupational Therapists (OT), nine Certified Occupational Therapy Assistants (COTA), and six Physical Therapists (PT) and two Physical Therapy Assistants (PTAs). With the current staffing, ratios for Occupational Therapy were 1:70 and PTs 1:82. This level of staffing should be adequate to address standard OT/PT practices in addition to the increased demand of physical and nutritional supports.<br><br>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.<br><br>At the time of this onsite review, Donna Groves OT continued to serve as the Habilitation Therapies Department Director as well as a backup member of the PNMT. Physical therapists included Kylie Fulmer PT, Paula Horn PT, Margaret Langley PT, Kristin Mishrell PT, Kris Ruuska PT, and Kim Walker PT. OTs included Janie Esptia OT, Donna Groves OT (HT Director), Jean Mykietyn OT (PNMT), Mamie Snead OT, Joe Thurman OT, Sandy Wallace OT, Paula West OT, and Heidi Wolfert OT.<br><br>All clinicians carried full caseloads with the exception of Donna Groves who served as the HT Director.<br><br>The Facility did document appropriate qualifications for licensed OTs, COTAs, PTs, and PTAs. Twenty-four of 24 staff (100%) were licensed to practice in the state of Texas.<br><br>Based on a review of continuing education completed in the last 12 months, 24 of 24 Habilitation Staff (100%) had completed continuing education related to their areas of practice.<br><br>Documentation of continuing education courses completed by the OTs and PTs were submitted. The continuing education attended by the clinicians included but was not limited to the following topics:<br>• ISP training<br>• Gait Biomechanics | |

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| | | • OT understanding of Lymphedema<br>• Orthotics<br><br>An OT/PT comprehensive Assessment was in place and provided upon admission and as indicated by a change in status. This assessment contained the following components:<br>• Diagnoses/Active Problems<br>• Medical History<br>• Medications<br>• Personal Preferences/Behavioral Considerations<br>• Motor/Functional Assessment<br>• Reflexive/Postural Abnormalities<br>• Lower extremity/Foot Assessment<br>• Upper Extremity/Hand Assessment and Fine Motor Function<br>• Movement Instructions/Transferring<br>• Mobility/Locomotion<br>• Positioning/Head of Bead Elevation<br>• Sensorimotor Function<br>• Activities of Daily Living<br>• Undressing/Dressing<br>• Grooming<br>• Bathing<br>• Toileting<br>• Oral Motor/Eating ability/Nutritional Status<br>• Risk Level<br>• Analysis<br>• Recommendations<br>• Factors for Community Placement<br><br>A new Assessment of Current Status format was in use at the Facility and included assessment by OT and PT. The outline submitted included medical history, medications, behavioral concerns, and other current health issues that would impact the delivery of OT and PT services. The assessment included physical assessment of sensory/motor/neuromuscular systems and functional motor and daily living skills performance. Physical Nutritional Management issues related to positioning supports, mealtime, medication administration, and oral care were also addressed. The outline also included sections to address the clinicians' analysis of findings (summary, strengths and needs), recommendations, measurable outcomes, and factors for community placement. Based upon initial review, the new format should address the concerns that | |

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| | | have been raised in previous reports regarding lack of comparative analysis directly related to past components of the initial comprehensive evaluation.<br><br>Therapists were instructed to analyze the clinical information as each section was completed so that reasoning was not lost. Skill acquisition and functional activities were to be considered throughout the assessment process. Functional and measurable objectives were to be outlined as indicated. Recommendations for supports and activities, other than direct therapy requiring a licensed professional, should be incorporated into the ISP so they may be integrated throughout the individual's daily routine. This was of significant concern to the Monitoring Team because all aspects of supports and services should be included in the ISP. . The ISP should include any supports during the rest of the day needed to support the direct therapy and make it maximally effective.<br><br>The comprehensive assessment was to be completed within 30 days of admission and the Assessment of current Status was to be completed at least annually to address services provided to the individual during the past year. A comprehensive assessment of specific systems and related areas was to occur upon a change in health status. A schedule for re-assessment was not included in the written report.<br><br>Generally accepted standards of a comprehensive OT/PT assessment include the following:<br>• Signed and dated by the clinician upon completion of the written report<br>• Dated as completed 10 days prior to the annual ISP<br>• Diagnoses and relevance to functional status<br>• Individual preferences, strengths, interests, likes, and dislikes<br>• Medical history and relevance to functional status<br>• Health status over the last year<br>• Medications and potential side effects relevant to functional status<br>• Documentation of how the individual's risk levels impact their performance of functional skills<br>• Functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day<br>• Evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work)<br>• Discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings<br>• Discussion of the expansion of the individual's current abilities<br>• Discussion of the individual's potential to develop new functional skills<br>• Comparative analysis of health and impact on functional status over the last | |

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| | | year<br>• Comparative analysis of current functional motor and activities of daily living skills with previous assessments<br>• Identify need for direct or indirect OT and/or PT services<br>• Reassessment schedule<br>• Monitoring schedule<br>• Recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs<br>• Factors for community placement and a determination of the most appropriate living environment<br>• Recommendations for services and supports in the community<br>• Manner in which strategies, interventions, and programs should be utilized throughout the day.<br><br>The total number of assessments reviewed was 18 (Samples #1, #2, and #3).<br>Comments are below:<br>• 88% (16/18) were signed copies of the original, and had dated signatures.<br>• 100% (18/18) of the assessments were dated as completed prior to the annual ISP meeting.<br>• 100% (18/18) included a section that reported health risk levels that were associated with PNM supports. This information was generally utilized for planning interventions and supports and for recommendations related to changes in the existing risk levels.<br>• 11% (2/18) included a comparative analysis section that clearly analyzed the individuals' level of status with previous years or assessments.<br>• 0% (0/18) included a monitoring schedule. The frequency of PNMP monitoring was not identified. The level of health risk was generally used to drive the frequency of monitoring for individual status, effectiveness of supports and interventions, or implementation of the PNMP.<br>• 0% (0/18) included a re-assessment schedule.<br>• 89% (16 of 18) provided a statement that "care could be provided in a less restrictive setting." However, 0% (0/18) included supports required for placement in a community setting. Although DSSLC contained a section that was called "Factors for Community Placement" the information contained within that section did not provide information regarding what supports would be needed.<br>• 100% (18/18) included evidence that communication and or collaboration was present in the OT/PT assessments.<br>• For the ISPs:<br>o 100% (18/18) of the ISPs submitted were current within the last 12 | |

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| | | months.<br>o 44% (8/18) of the current ISPs with signature pages submitted were attended by OT only. No PTs attended these meetings.<br>o 39% (7/18) of the current ISPs with signature pages submitted were attended by PT only. No OTs attended these meetings.<br>o 11% (2/18) were attended by both the OT and PT<br>o 6% (1/18) were not attended by either the OT and PT<br><br>Per Habilitation Director, this was an area of focus that should show improvement by the next compliance visit.<br><br>There were two individuals newly admitted to the Facility (Sample #3) since the last onsite review. Two of two individuals (100%) received the required OT/PT assessments within 30 days of admission.<br><br>Audits of the assessments had recently begun at DSSLC. As of this review, only eight had been completed. Audits were completed by the department director for assessments completed by clinicians to establish competency for each. At this time, the audits were based on pulled sample but eventually the goal was to have the audit completed prior to the ISP so that any areas that were identified as deficient could be corrected by the therapist prior to submitting to the IDT. This process was in its infancy and informal at this time; the Habilitation Services Director reported plans to formalize the process. | |
| P2 | Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices | Based on review of comprehensive OT/PT assessments or updates, PNMPs and associated instructional plans, Activity Plans, Treatment plans and clinician progress notes for 18 individuals (Samples #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.<br><br>Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. Please refer to Provisions O.2 regarding assessments in response to a change in status.<br><br>An area of improvement was noted with regards to the team's response to falls.<br>• Since the last compliance visit, DSSLC had developed a Fall Prevention manual that contained the following components:<br>o Team Designation<br>o Performance Indicators<br>o Procedures<br>o Identification of Risk<br>o Creation of a Safe Environment | Noncompliance |

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| | and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression. | o Methods of reporting Falls<br>o Prevention Strategies<br>o Program Evaluation<br>• The QA/QI Improvement Council was in charge of reviewing falls across campus. This team consisted of:<br>o HT Director<br>o All Unit Directors<br>o Director of Behavioral Services<br>o Assistant Director of Programs<br>o Director of Residential Services<br>o Center Director<br>o Chief Nurse Executive<br>• Performance indicators included the number of falls, number of injuries related to falls, and the reduction of falls for the top five individuals with the most falls.<br>• Included in the Fall Process were criteria for Falls Risk Assessment, Environmental Safety Assessment, reporting procedures, program evaluation, staff education and development of Action Plans to address the risk.<br><br>Based on reviews of PNMPs for 18 individuals (Samples #1, #2, and #3), equipment was specified for 18 of 18 (100%) plans reviewed.<br><br>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 ISP and were generally updated as needed due to a change in status.<br><br>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.<br><br>At the time of this review, there were seven (1% of the Facility population) individuals receiving direct OT services and twelve individuals (2%) who were receiving direct PT services.<br><br>Findings identified as part of the OT/PT assessment 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 | |

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| | | direct therapy services.<br><br>Justification for continued therapy or discharge was well documented in the progress notes.<br><br>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. Please refer to Provision O.3 for additional information.<br><br>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:<br>• In eight of 19 (42%) observations, staff were following mealtime plans.<br>• In 11 of 23 (47%) observations staff were following positioning instructions.<br><br>Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan included:<br>• Individual #94 was not provided with cues to take small bites and sips, or swallow between bites, thus increasing the risk of choking<br>• Individual #153 was eating at an unsafe rate with no cues to slow down.<br>• Individual #381 was observed slid down in chair with a posterior pelvic tilt resulting in increased pressure to the buttocks thus increasing the risk of a pressure sore<br>• General safe mealtime practices such as providing liquids during the meal and encouragement to eat at a slow pace were also not observed.<br><br>Overall, there was approximately 10% improvement since the last compliance visit with regards to ensuring individuals is provided services in accordance with the PNMP. | |
| 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:<br>• Aspiration Pneumonia<br>• PNMP philosophy<br>• Techniques and equipment for individuals served<br>• Lifting and Transfer<br>• Positioning<br>• Dining/eating/oral intake<br>• Monitoring Individuals for PNM issues | Noncompliance |

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| | | As of this review, percentage of staff trained on basic PNM related issues included:<br>• Lifting People (98%)<br>• Physical Management (100%)<br>• Preventing Aspiration Pneumonia (97%)<br>• Personal Care Services (99%)<br><br>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 People", "CPR" and "Preventing Aspiration Pneumonia". Missing from the annual trainings were Physical Management Skills and Personal Care Services.<br><br>There was a process to ensure regularly trained staff were provided with competency based training as indicated by the plan of care but not one 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, falls or other PNM related issues.<br><br>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:<br>• Where is the PNMP/Dining Plan located? (100% answered correctly)<br>• What kind of transfer do they require? (100%)<br>• What do you look for to ensure the individual is in the correct position? (50%)<br>• See Provision O.4 for additional information.<br><br>This lack of understanding, combined with the lack of implementation reported in Provision P.2, indicates there is a need for refresher training and periodic retraining on individuals' supports and services when staff do not implement them accurately. | |
| 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 | 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.<br><br>DSSLC had a repair log that identified the date a wheelchair or other adaptive equipment was repaired, the name of the individual, who completed the order, and the part repaired. Missing from the log was information regarding when the repair request was initiated; therefore, it was impossible to determine if repairs were being provided in a timely manner. | Noncompliance |

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| | effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions. | 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).<br><br>A policy/protocol that addressed the monitoring process and provided 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.<br><br>A policy/protocol addressing the monitoring process did exist and provided information regarding frequency of monitors and staff responsible. Based on review of the DSSLC PNM policy rev 10/12, a system was in place to monitor staff implementation of PNMPs and other OT/PT interventions which included:<br>o Definition of monitoring process<br>o Identifies monitors and their roles and responsibilities<br>o Formal schedule for monitoring to occur<br>o Re-evaluation of monitors on an annual basis by therapists and/or assistants<br>o Results of monitoring activities in which deficiencies noted are formally shared for appropriate follow-up by the relevant supervisor<br><br>Although the data system collected data, it was not aggregated in a way that allowed productive trending and analysis. See Provision O.7 for more information.<br><br>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. A concern was that the monitoring forms contained a section labeled compliance and noncompliance. Compliance was achieved with a score of 80% or higher. The problem was that each question was weighted equally resulting in staff being allowed to not implement the PNMP and still have a score high enough to be rated as in compliance.<br><br>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 the data aggregated by areas addressed by the PNM monitoring form. There was no system in place that allowed for the overall tracking and trending of the monitoring data. A system did accumulate the data but did not provide information regarding the difference between effectiveness of the plans and staff implementation of the plans. | |

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

1. Integrate direct and indirect supports into the ISP through the development of SAPs that include measurable goals with performance criteria.
2. 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)
3. In order to determine timeliness of repairs, the wheelchair log data base should contain the date the wheelchair was broken and the date repaired. At the time of the review, only the repair date was available. (Provision P.4)
4. Implementation of coaching and skills drills with staff was indicated to ensure that they were consistently able to discuss the rationale behind recommended interventions and to recognize their role in management of health risk issues (Provision P3).
5. Conduct routine validation of monitoring and training completed by the PNMPCs and home supervisors (Provision P4).
6. There was a continued need to develop programs to address increasing or expanding functional skills. OT/PT staff should also model ways to promote skill acquisition and capitalize on opportunities during groups already implemented by direct support staff in the homes and day programs. Therapists should push forward with the development of more collaborative skill acquisition plans and modeling with groups to enhance the day programs and activities occurring in the homes. (Provision P.2)

| SECTION Q: Dental Services | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment, 9/24/12<br>2. DSSLC Action Plan, 9/24/12<br>3. DSSLC Presentation Book for Section Q<br>4. DSSLC Policy Dental Services Overview, dated 6/30/11 (no policy number)<br>5. List of individuals who currently are provided suction toothbrushing<br>6. List of individuals who have been identified as requiring suction toothbrushing but have not started a suction toothbrushing program<br>7. DSSLC Dental Services Quality Assurance Protocol DS-25, which was completed on 9/25/12.<br>8. Last two annual dental summaries, dental progress notes, and integrated progress notes (IPNs) for past six months, most recent ISP, and addendums to the ISP for past six months for Individuals #119, #110, #20, #526, #517, #240, #689, #351, #669, and #334<br>9. Ten CDLPs, which were selected at random by the Facility's electronic database system.<br>10. CLDP for Individual #505<br>11. List of individuals who require oral sedation, intravenous anesthesia (TIVA), and general anesthesia<br>12. List of all dental emergencies, and corresponding dental record for the dental emergency<br>13. Plans to minimize the use of sedating medications for dental procedures. The sample was selected by the Facility from a list of individuals who were provided a dental desensitization program.<br>**People Interviewed:**<br>1. Eric Wear DDS, Dental Director<br>2. Pam Fourrier, Dental Assistant<br>**Meeting Attended/Observations:**<br>1. Observations of oral hygiene outcomes at living area Cedar Falls |
| | **Facility Self-Assessment:**<br>The Monitoring Team concurs with the Facility's self-assessment of noncompliance and action plans for Provisions Q.1 and Q.2.<br><br>Most items reviewed as part of the self-assessment involved data on status. This is a positive step. However, it is essential that the Facility identify the processes for gathering data and evaluate the data in terms of the requirements of the provision. For example, Provision Q1 requires the Facility to provide individuals with timely routine dental care. The Facility assessed provision of routine dental care by determining if annual dental examinations were completed within 365 days; this item identified how many annual dental examinations met that standard for timeliness, but it reported only 276 annual dental examinations and did not assess how that related to dental care for a population of 492 individuals. Also, the activities engaged in for Provision Q2 reported that policies were current and accurate but did not report whether policies addressed each of the items required by the provision.<br><br>The action plan for Provision Q included many thoughtful action steps, that if developed and implemented, will help lead to compliance. The action plan should be undated to reflect the monitoring Teams |

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| | recommendations for Provisions Q1, and Q.2. |
| | **Summary of Monitor's Assessment:**<br>Dental services has significantly improved since the last compliance review.<br><br>The Facility maintained an effective mechanism that ensured the delivery of emergency dental services, and maintained a robust staff of dentists. The Monitoring Team noted that the Facility had significantly improved on ensuring that IPNs were documented in a way that non-dental staff could understand, and that the notes reflected the dental services provided to the individual. The Facility obtains dental x-rays in accordance with standard of care practice, and completes a dental summary that clearly delineates the individual's comprehensive dental needs, including behavioral issues. The Monitoring Team was pleased to learn that staff issues had been addressed and that the dental office reports adequate staff to perform its activities, and that additional space was provided that enables clerical activities to be done outside of the dental examination room. The Monitoring Team was also pleased to learn that the Facility had developed an external quality review process that enables an outside dentist to review the clinical practice of the Facility's dentists and hygienists. The Monitoring Team also noted that dental summaries were being completed more comprehensively then when previously reviewed. On the other hand the Monitoring Team is very concerned with the less then adequate level of oral hygiene, and lack of fully implementing suction toothbrushing at the living area. Of significant concern is the lack of dental office participation at the annual IDT, and CDLP meetings.<br><br>**Provision Q1:** The Facility maintained an effective mechanism that ensured the delivery of emergency dental services, and maintained a robust staff of dentists. The Monitoring Team noted that the Facility had significantly improved on ensuring that IPNs were documented in a way that non-dental staff could understand, and that the notes reflected the dental services provided to the individual. The Facility obtains dental x-rays in accordance with standard of care practice, and completes a dental summary that clearly delineates the individual's comprehensive dental needs, including behavioral issues. The Monitoring Team was please to learn that staff issues had been addressed and that the dental office reports adequate staff to perform its activities, and that additional space was provided that enables clerical activities to be done outside of the dental examination room. The Monitoring Team is very concerned with the less then adequate level of oral hygiene, and lack of fully implementing suction toothbrushing at the living area. The Monitoring Team is also concerned that the Facility had yet to implement a dental hygiene database. Compliance with Provision Q.1 requires that 100% of the individuals achieve a level of good oral hygiene, unless there is clinical documentation in the IPNs and Dental Summary explaining the rationale why the individual can not achieve 100% level of good oral hygiene. Compliance also requires implementation of a mechanism, such as the pending dental database, that ensures efficient and efficacious dental scheduling, and a process to readily identify specific dental services that are pending, and dental services that had been previously provided to the individual<br><br>**Provision Q2:** The Monitoring Team noted significant improvement with Provision Q.2. For example, the Monitoring Team was very pleased to learn that the Facility had developed an external quality review process that enables an outside dentist to review the clinical practice of the Facility's dentists and |

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| | hygienists. The Monitoring Team also noted that dental summaries were being completed more comprehensively then when previously reviewed. However, the Monitoring Team determined that the Facility is not in compliance with Provision Q.2, because the QA process did not assess for potential adverse outcomes following dental services, and because of the significant lack of representation of oral health care in the ISP, and in the CDLP process. Importantly, the Facility must implement its pending database solution, or develop an alternative mechanism that will efficiently and efficaciously allow scheduling of individuals for all dental services, and enable review of all past dental appointments, all pending appointments, and all services that were provided and that are pending. Importantly, the Facility must update or develop policies and/or procedures to clearly delineate all dental practices. |

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| Q1 | Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards. | 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.<br><br><u>Staffing And Administration</u><br>The Facility's new dental director had been with the Facility for six months at the time of this review, and had completely evaluated dental services. The director's time is divided into 90% administrative and 10% clinical. The Facility continued to have one full time dentist, who provided direct care 100% of the time. The Facility maintained contracts with a dental anesthesiologist, who provided i.v. sedation to individuals approximately 5-6 days per month, and an oral surgeon who provides oral surgery approximately 2 times per month.<br><br>The Facility maintained two full-time positions for dental hygienists, which were filled, and reported by the medical director to meet the needs of individuals.<br><br>The Facility had two positions for full-time dental assistants; however, one of these positions was vacant, albeit in the process of being filled, at the time of the compliance visit. Dental assistants provide both clinical support to the dentists and hygienists, and maintain clerical support for the dental office.<br><br>Since the last Monitoring Team review, the dental office expanded to enable a separate clerical area, enabling more room in the dental treatment room, and for privacy when managing confidential records and phone calls.<br><br><u>Oral Health Care</u><br>By using an electronic randomizer (randomizer.org), the Monitoring Team selected ten | Noncompliance |

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| | | individuals to assess and reviewed their annual dental examination, as of 10/1/12 and prior; the Monitoring Team requested the last annual dental summaries, and copies of all dental notes, integrated progress notes for past six months, and of the past 12 months Individual Support Plans (ISPs) and addendums.<br><br>Of the dental summaries, four (40%) demonstrated good oral hygiene, while five (50%) demonstrated fair oral hygiene, and one (10%) demonstrated poor oral hygiene. Facility data on oral hygiene demonstrates a broad margin among the various living areas. For example, in October of 2012, 41% of the individuals were rated as having good oral hygiene; this was an improvement since March 2012, when only 19% of the individuals were rated as having good oral hygiene, and on Eastfield, 40% of the individuals were rated as having good oral hygiene in October of 2012, while only 21% were rated as good in March of 2012. Conversely, Timberhill were reported to have 59% of the individuals as having good oral hygiene in October 2012, and 70% in March of October 2012. The Facility should require 100% compliance with good oral hygiene rating, unless there is clinical documentation in the IPNs and Dental Summary explaining the rationale why the individual cannot achieve a level of good oral hygiene, and should ensure corrective action is taken when monitoring finds less than good oral hygiene without a good clinical rationale.<br><br>Of the 10 dental summaries, three (30%), was determined to have light calculus formation, while three (30%) demonstrated moderate calculus formation and two (20%) had heavy calculus formation, one (10%) had severe calculus formation, and one (10%) was unable to be assessed because of behavior issues. The Monitoring Team noted a improving trend with regards to calculus formation<br><br>Of the 10 dental summaries, one (10%) were associated with no bleeding, while three (30%) were associated with moderate bleeding,zero (0%) were associated with heavy bleeding, and six out of ten (60%) did not indicate pathology. Improving trend was noted by the Monitoring Team with regard to gingival bleeding.<br><br>Of the 10 dental summaries, three (30%), was determined to have light plaque and a very low risk for periodontal disease, while six (60%) were determined to moderate plaque formation, and one (10%) demonstrated heavy plaque formation and a high risk for periodontal disease. The Monitoring Team noted significant improvement with reducing dental plaque formation.<br><br>Overall, the Monitoring Team noted significant improvement with the oral health condition of individuals served by the dental office; however, oral hygiene efforts must continue to significantly improve before compliance can be achieved. The Monitoring Team anticipates with the current focus on dental services by the Facility, this trend will | |

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| | | continue to improve.<br><br>Oral Hygiene Efforts at the Living Area: The Monitoring Team had an opportunity to observe individuals' general oral health care levels at living area Cedar Falls, by inspecting individuals' oral cavity during casual conversation with individuals. The Monitoring Team did not identify any case of food debris, or glistening plaque during its observation at Cedar Falls, which was a marked improvement from the beginning of the Monitoring Team's review of the Facility.<br><br>Oral Hygiene Efforts At The Living Area--Suction Toothbrushing: The Facility revised its protocol for oral care for individuals who were enterally fed or high risk for aspiration, on 8/27/12. The new policy delineates qualifying conditions for the use of suction toothbrushing, and when to assess individuals for suction toothbrushing. Although 88 individuals were reported to be provided suction toothbrushing, the dental director indicated that not all individuals had been completely assessed, and that further assessment to determine the need for suction toothbrushing occurs at the time of the annual dental assessment.<br><br><u>Dental X-rays</u><br>The Monitoring Team discussed the Facility's practice of obtaining dental X-rays. The dental director reported that individuals receive screening x-rays at least every two years, and additional x-rays as clinically required. The Monitoring Team reviewed the dental summaries of ten individuals and noted that nine out of ten (90%) of the individuals had screening dental x-rays within the past 12 months.<br><br><u>Routine And Emergency Dental Services</u><br>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 of dental services that were provided. The Facility was expected to launch a dental database system, which would enable efficient and efficacious tracking of dental appointments and services; however, there was a delay with installing the database, and it is expected that the system will be up and running at the next Monitoring Teams scheduled review.<br><br>Dental Emergencies: The dental director informed The Monitoring Team 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 document 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 | |

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| | | delineate the procedure that is practice at the Facility.<br><br>Review of all reported dental emergencies indicated that a total of 22 dental emergencies were referred to the dental office for evaluation. Twenty-two of the 22 individuals triaged by the dental office (100%) were evaluated by the dental office. Effectively 100% of individuals referred for emergency dental evaluation were triaged appropriately. Furthermore, the dental records were reviewed for all 22 individuals who were triaged for a dental emergency, and the Monitoring Team determined effective follow-up was provided.<br><br>The Monitoring Team determined that the Facility had an effective process to address emergency dental needs of individuals supported by the Facility.<br><br><u>Review of Integrated Progress Notes (IPN)</u><br>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 and IPNs of Individuals #119, #110, #20, #526, #517, #240, #689, #351, #669, and #334. A total of ten IPNs were reviewed, and in ten out of ten (100%), the Monitoring Team determined that the quality of the dental notes in the IPNs was adequate, and clearly delineated the clinical issues, follow-up plans, and issues relevant to providing medical and direct care to the individuals. The Monitoring Team noted that the Facility made marked improvement by documenting IPNs to reflect dental treatments, and plans.<br><br><u>Summary</u><br>The Facility maintained an effective mechanism that ensured the delivery of emergency dental services, and maintained a robust staff of dentists. The Monitoring Team noted that the Facility had significantly improved on ensuring that IPNs were documented in a way that non-dental staff could understand, and that the notes reflected the dental services provided to the individual. The Facility obtains dental x-rays in accordance with standard of care practice, and completes a dental summary that clearly delineates the individual's comprehensive dental needs, including behavioral issues. The Monitoring Team was pleased to learn that staff shortage issues had been addressed, and that the dental director reported that there is now adequate staff to perform dental activities, and also that additional space was provided that enables clerical activities to be done outside of the dental examination room. The Monitoring Team is very concerned with the less then adequate level of oral hygiene as identified by dental examination, and lack of fully implementing suction toothbrushing at the living area. The Monitoring Team is also concerned that the Facility had yet to implement a dental hygiene database. Compliance with Provision Q.2 will require that the Facility has an effective process in place to | |

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| | | monitor oral hygiene and establish corrective actions to ensure individuals achieve a level of good oral hygiene, unless there is clinical documentation in the IPNs, and Dental Summary explaining the rationale why the individual cannot achieve a level of good oral hygiene, and a plan to improve the Individual's oral hygiene to the extent possible. Compliance also requires implementation of a mechanism, such as the pending dental database, that ensures efficient and efficacious dental scheduling, and a process to readily identify specific dental services that are pending and dental services that had been previously provided to the individual | |
| Q2 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints. | Provision Q.2 addresses the Facility's development and implementation of policies and procedures specific to dental services, and integration of dental services into the IDT process. These policies must address, and the Facility must implement, 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.<br><br><u>Review of Individual Support Plans (ISPs) for Inclusion of Dental Services</u><br>The Monitoring Team selected the ISPs for ten randomly selected individuals by utilizing an electronic random generative (randomizer.org), and of the ten ISPs reviewed, zero out of ten (0%) delineated necessary supports and services for dental care, and zero out of ten (0%) documented the individual's current dental status, prognosis, risks and benefits of providing dental services and not providing dental services, and potential challenges preventing dental services. Importantly, dental services represented themselves at the ISPs in zero out of ten (0%) occasions. The Monitoring Team remains very concerned with the lack of meaningful representation of dental service needs at the ISP meetings.<br><br><u>Review of the Dental Discharge Summaries used for Community Living Discharge Planning (CDLPs) Meetings</u><br>The Monitoring Team requested the dental summaries used for the most recent ten CLDP meetings.<br><br>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 were required for oral health care and hygiene. The Monitoring Team review the CDLP, post discharge monitoring report, and 90 day ISP meeting for Individual #505, and noted a complete lack of appropriate review of dental services during the post move monitoring period. It is essential that dental services, including oral hygiene be assessed during the post move monitoring period, and that all | Noncompliance |

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| | | necessary supports and services for dental health care are in place, and being actively provided to the individual.<br><br><u>Use of General Anesthesia, Intravenous and Oral Sedation Use</u><br>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 exacerbations.<br><br>The Facility was currently being provided with one TIVA day per week, which according to the dental director is adequately meeting the needs of individuals served by the dental clinic.<br><br><u>Review of the Dental Summary Forms</u><br>Review of the dental summaries provided for review demonstrated that the summaries provided meaningful information that enabled team members to gain 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.<br><br>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.<br><br><u>Dental Desensitization, and Interventions to Minimize the Use of Sedating Medications, and Restraint</u><br>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 psychology assistance, and the dental hygienist at the Facility. In collaboration with the | |

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| | | dentist, the Facility identified 10 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. Refer to Provision J4 for additional information.<br><br><u>Quality Assurance for Dental Services</u><br>Subsequent to the last Monitoring Team review, the Facility enhanced its dental quality assurance process by developing a quality assurance policy for dental services called DSSLC Dental Services Quality Assurance Protocol DS-25, which was completed on 9/25/12. The new protocol states that an outside dentist will review diagnosis, treatments, and records, to ensure that standard of care is being provided by the Facility's dentists and hygienists. The Facility also developed a corresponding dental QA form for the outside dentist to use for the QA process. At the time of this review, there was no data available on the review process for the Monitoring Team to review. Importantly, the Facility had not developed a dental QA process to evaluate treatment outcomes, and potential adverse outcome following dental procedures. For example, the Facility should be closely monitoring for injuries that occur with in 48 hours following a dental procedure, and any reported cases of pneumonia for ten days following a dental procedure.<br><br><u>Missed Appointments and Dental Scheduling</u><br>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.<br><br><u>Summary</u><br>The Monitoring Team noted significant improvement with Provision Q.2. For example, the Monitoring Team was very pleased to learn that the Facility had developed an external quality review process that enables an outside dentist to review the clinical practice of the Facility's dentists and hygienists. The Monitoring Team also noted that dental summaries were being completed more comprehensively then when previously reviewed. However, the Monitoring Team determined that the Facility is not in | |

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| | | compliance with provision Q.2, because the QA process did not assess for potential adverse outcomes following dental services, and because of the significant lack of representation of oral health care in the ISP, and in the CDLP process. Importantly, the Facility must implement its pending database solution, or develop an alternative mechanism that will efficiently and efficaciously allow scheduling of individuals for all dental services, and enable review of all past dental appointments, all pending appointments, and all services that were provided and that are pending. Importantly, the Facility must update, or develop, policies and/or procedures to clearly delineate all dental practices. | |

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

1. The Facility must improve on providing oral hygiene at the living area. (Provision Q.1)
2. The Facility must ensure that all individuals who require a suction toothbrushing, are provided that service and needed support. (Provision Q.1)
3. Either implement the DADS dental database or develop and implement a mechanism to efficiently and efficaciously manage dental appointments, so that all past appointment, can be reviewed, along with all treatments that were provided and that are pending. (Provisions Q.1, and Q.2)
4. Oral health care services, and support needs, as well as all oral health care issues, and associated treatment risks, must be adequately represented in the ISP. (Provision Q.2)
5. Ensure that the CLDP process is well represented by dental services, and that all necessary dental services are closely monitored during the post move monitoring period. (Provision Q.2)
6. Develop a specific policy and procedures that delineate all of the Facility's programs to provide dental desensitization, and other methods to reduce the use of restraint for dental procedures. (Provision Q.1)
7. Improve the dental QA process by ensuring that the Facility monitors and reports data on adverse outcomes following dental procedures. For example, develop regular assessments to determine the number of individuals who develop pneumonia (including but not limited to aspiration pneumonia) that occur within ten days following a dental procedure, and all individuals who sustain and injury or experience a behavioral exacerbation within the first 48 hours after a dental procedure.

| SECTION R: Communication | |
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| 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:**<br>**Documents Reviewed:**<br>1. DSSLC Self Assessment 9/24/2012<br>2. DSSLC Action Plan 9/24/12<br>3. Facility Section R Presentation Book<br>4. DSSLC Communication Services Policy CMGMT-23, rev 11/1/09<br>5. Record Reviews of Individuals:<br>• Sample 1: Individuals #13, #35, #37, #441, #499, #503 and #750<br>• Sample 2: Individuals #105, #134, #243, #279, #373, #432, #466, and #715<br>• Sample 3: Individuals #273, and #296<br>• Sample 4: Individuals #92, #153, #187, #218, #308, #467, #488, and #690<br>• Sample 5: Individuals #226, #232, #347, #594, and #669<br>• Sample 6: Individuals #49, #172, #248, #509, and #566<br>6. Communication Master Plan<br>7. List of current SLPs, caseloads and ratios<br>8. Copies of each SLP's current license and ASHA certification<br>9. Continuing education and training completed by the SLPs in the past 12 months<br>10. Facility list of new admissions since the last review<br>11. Tracking log of SLP assessments completed since the last review<br>12. Facility list of individuals with severe language deficits<br>13. Facility list of individuals with PBSPs and replacement behaviors related to communication<br>14. PBSP minutes and attendance rosters for the past six months<br>15. Facility list of individuals with Alternative and Augmentative communication (AAC) devices<br>16. Facility AAC screening forms<br>17. Facility AAC-related database reports/spreadsheets<br>18. Facility list of general common area AAC devices<br>19. Facility list of individuals receiving direct communication-related intervention plans<br>**People Interviewed:**<br>1. Joy Sibley CCC-SLP Director of Communication Therapy<br>2. Donna Groves OTR Director of Habilitation Services<br>3. Erin O'Toole CCC-SLP<br>4. Eight DCPs (Houston Park, Cedar Falls, Timberhill, and Westridge)<br>**Meeting Attended/Observations:**<br>3. Mealtimes and Transitions- Houston Park, Cedar Falls, Westridge, Timberhill<br>4. Life Skills Cedar Falls and 13A |
| | **Facility Self-Assessment:**<br>Based on a review of the Facility's Self-Assessment, with regard to Section R of the Settlement Agreement, the Facility found it was in noncompliance with Provisions R.2, R.3 and R.4 and in compliance with Provision R.1. This was inconsistent with the Monitoring Team's findings of noncompliance with all |

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| | provisions. For Provision R.1, DSSLC stated that all SLP positions were full and their current staffing ratio was 1:70 and therefore compliance was achieved. The Monitoring Team disagreed with this rating as Provision R.1 encompasses all data from R.2, R.3 and R.4 in determining overall compliance with R.1<br><br>The Facility submitted two documents, including: DSSLC Self Assessment and the DSSLC Action Plan. The DSSLC Self Assessment listed the steps the Facility staff completed or planned to complete to conduct the self-assessment, and the subsequent results for the completion of these tasks. The Action Plans documented the status of action steps that had been completed, were in process, and/or had not been started.<br><br>The Facility Self-Assessment included data or findings from the self-assessment activities to support the Facility's conclusion of whether it was or was not in substantial compliance with the requirements of the Settlement Agreement for Section R. A review of the Facility Self-Assessment for Section R identified activities engaged in to conduct the self-assessment.<br><br>Overall, the Self Assessment and Action Plans included relevant steps that would assist in the state in gaining compliance; however, the planned activities at times were not consistently in line with what the Monitoring Team assesses as indicated in this report. |
| | **Summary of Monitor's Assessment:**<br>Overall, the comprehensiveness of the Speech Assessments continued to improve but still lacked information regarding how communication strategies or programs could be implemented consistently and integrated throughout the day and throughout multiple tasks. Implementation of communication programs remained extremely low and staff knowledge of how to form effective communication with the individuals was not evident at the home level.<br><br>**Provision R.1:** This provision was determined to be not in compliance. DSSLC has filled all of their positions but remained not compliant due to lack of the SLPs' presence in all facets of care in which their expertise was needed.<br><br>**Provision R.2:** This provision was determined to be not in compliance. Individuals identified as having decreased communication did not have their plans implemented as written or throughout the day in which opportunities for increased communication were presented.<br><br>**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.<br><br>**Provision R.4:** This provision was determined to be not in compliance. DSSLC did not have a comprehensive monitoring system that covered the presence and condition of the device, implementation of the device, as well as SLP participation in care. |

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| 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 seven individuals who were chosen from a list provided by DSSLC of individuals who they identified as being at a high risk of aspiration. The sample accounted for 11% of those identified by DSSLC as being at "high" risk for aspiration.<br><br>Sample #2 consisted of nine individuals and was chosen from the list of individuals who were diagnosed with an aspiration and/or choking event over the past 6 months.<br><br>Sample #3 consisted of two individuals who accounted for 100% of new admissions since the previous compliance review.<br><br>Sample #4 consisted of eight individuals identified by the Facility with severe expressive or receptive language disorders.<br><br>Sample #5 consisted of five individuals with a PBSP and communication deficits.<br><br>Sample #6 consisted of five individuals receiving direct speech services.<br><br>This provision of the Settlement Agreement includes a number of requirements that are addressed in subsequent provisions within Section R and which have the ability to affect the Facility's compliance with the Settlement Agreement. This provision will address compliance with current staffing, staff qualifications, adequate number of speech language pathologists, and continuing education. The SLP assessment process and the development and implementation of programs are discussed in Provision R.2. Staff training will be addressed in Provision R.3 and the Facility's monitoring system will be presented in Provision R.4. Compliance in Provision R1 related to the adequacy of clinicians must be determined by compliance in Provisions R2 through R4.<br><br><u>Staffing:</u><br>At the time of the review, DSSLC had seven full time Speech Language Pathologists plus one SLP who was assigned to the PNMT. Each Therapist carried a full caseload with the exception of the director.<br><br>The current ratio of therapist to client ratio was 1:70. This ratio should allow for the appropriate follow up or involvement of the SLP in all facets of the individuals care.<br><br><u>Qualifications:</u><br>The Facility did document appropriate qualifications for licensed SLPs.<br>• Six of Seven staff (85%) were licensed to practice in the state of Texas.<br>• Six of Seven staff (85%) had evidence of ASHA certification. There was one | Noncompliance |

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| | | therapist who was completing their clinical fellowship year and was being provided with the necessary supervision to earn their certification and license.<br><br>The Facility did not provide an adequate number of speech language pathologists or other professionals (i.e. AT specialists) with specialized training or experience. Evidence was as follows:<br>• Although the number of therapists filled all the available positions, therapists passed the development of programs to individuals who lack the expertise needed to write functional and sequential goals. This area has improved but still requires more consistency in implementation.<br>• Individuals did not receive direct services as indicated by need or request by the IDT (see Provision R.3)<br>• Devices were not utilized and systems or devices were not monitored at a frequency that ensured appropriateness and continued use of the device (See Provision R.3)<br><br><u>Continuing Education:</u><br>Documentation of continuing education courses was not provided by DSSLC, however continuing education was completed by staff as evidence by all therapists being in good standing with the national and state level boards.<br><br><u>Facility Policy:</u><br>DSSLC had a localized Communication Services Policy (CMGMT-23, rev 11/1/09). The policy contained the following components:<br>• Roles and responsibilities of the SLPs (meeting attendance, staff training etc.).<br>• Timelines for completion of new admission assessments<br>• Criteria for providing an update<br>• Outlines assessment schedule.<br>• Frequency of assessments/updates.<br><br>Missing from the policy was:<br>• Addressing a process for effectiveness monitoring by the SLP.<br>• Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution.<br>• Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication<br>• Methods of tracking progress and documentation standards related to intervention plans. | |

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>If the DSSLC policy contained all the components listed above then the policy would be considered comprehensive. The Facility should review and revise the policy.</td><td></td></tr>
<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><u>Assessment Plan:</u><br>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:<br><br>
<table>
<tr><td>Priority 1</td><td>Most dependent on others for their wants and needs (care code 3 or 4)</td><td>Completed</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>
<br>Care Code Legend:<br>1=no noticeable articulation problems and/or uses complex sentences<br>2=exhibits occasional articulation and/or uses only simple sentences<br>3=articulation problems are noticeable in speech and uses only phrases<br>4=speech is largely unintelligible by strangers and/or meaningful speech is absent or limited to a few simple words<br><br>The master plan also contains exceptions should an assessment be needed prior to the individual spot on the plan, which included:<br>• Admission to the Facility<br>• Transition or expected transition to the community<br>• Significant changes in communication skills<br>• Participation in therapy<br>• Concerns with existing AAC<br>• Referral by the IDT<br>The master plan provided the framework needed to ensure all individuals were provided with new comprehensive assessments by 2015. Priority 4 and 5 individuals had much</td><td>Noncompliance</td></tr>
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| | | milder speech and language deficits and were able to communicate more effectively and therefore were to be provided their new comprehensive assessment at a later date.<br><br>Per review of new admissions (sample #4):<br>• One of two individuals (50%) received a communication screening or assessment within 30 days of admission or readmission.<br><br><u>Communication Assessment:</u><br>Per generally accepted clinical standards, a comprehensive assessment should contain the following elements, at a minimum:<br>• Signed and dated by the clinician upon completion of the written report<br>• Dated as completed 10 days prior to the annual ISP<br>• Diagnoses and relevance of impact on communication<br>• Individual preferences, strengths, interests, likes, and dislikes<br>• Documentation of how the individual's communication abilities impact their risk levels<br>• Description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day.<br>• Evidence of observations by SLPs in the individual's natural environments (day program, home, work)<br>• Evidence of discussion of the use of a Communication Dictionary as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who were non-verbal<br>• Discussion of the expansion of the individual's current abilities<br>• Discussion of the individual's potential to develop new communication skills<br>• Effectiveness of current supports, including monitoring findings<br>• Comparative analysis of health and functional status from the previous year<br>• Comparative analysis of current communication function with previous assessments<br>• Identify need for direct or indirect speech language services<br>• Reassessment schedule<br>• Monitoring schedule<br>• Recommendations for direct interventions and/or skill acquisition programs including the use of AAC as indicated for individuals with identified communication deficits<br>• Factors for community placement and a determination of the most appropriate living environment<br>• Recommendations for services and supports in the community<br>• Manner in which strategies, interventions, and programs should be utilized | |

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| | | throughout the day.<br><br>Based on review of 31 assessments (Samples #1, #2, #3, #4 and #5), 14 of 31 (45%) individuals had comprehensive assessments that contained each of these elements.<br><br>Those assessments that were not considered to be comprehensive did not include the following elements:<br>• Manner in which strategies, interventions, and programs should be utilized throughout the day<br>• Factors for Community Placement<br><br>Although there was a section titled "Factors for Community Placement," this section was often generic and not specific to the individual. Under the heading it simply stated "Based upon identified needed supports/services in the area of communication therapy, these supports and services can be provided in a less restrictive setting." This statement may have addressed the requirement for the professional to make a determination of appropriateness of movement to a more integrated setting (although it was limited to communication therapy) but provided little to no information regarding what supports would be necessary to ensure successful transition to community living.<br><br>Zero of eight Individuals (0%) (Sample #4) who had communication devices or programs were provided with the appropriate follow up of such devices or programs. For example:<br>• Individuals #691 and #175 had AAC objectives but there was no evidence of monthly or quarterly review by the SLP or QMRP.<br><br><u>SLP and Psychology Collaboration:</u><br>Based on review of five records for individuals in Sample #5 the following was noted:<br>• Three of five communication assessments and PBSPs reviewed (60%) addressed the connection between the PBSP and the recommendations contained in the communication assessment.<br>• Four of five (80%) communication assessments reviewed contained evidence of review of the PBSP by the SLP. For example, Individual #160's communication assessments stated an adverse reaction to hand over hand while the PBSP recommends Hand over Hand prompts. The PBSP was not, however, revised based on this discrepancy.<br><br>Based on review of the PBSC (Positive Behavior Support Committee) meeting minutes from 4/1/2012 TO 9/5/2012, participation by the SLP was noted in 16 of 22 (72%) meetings | |

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| R3 | Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings. | <u>Integration of Communication in the ISP:</u><br>Based on review of the ISPs for 25 individuals in Samples #1, #2, #3, and #4 the following was noted:<br>• In 21 of 25 ISPs reviewed (84%) for individuals with communication needs, an SLP attended the annual meeting.<br>• In 16 of 25 ISPs reviewed (64%), the type of AAC and/or communication supports was identified.<br>• Communication Dictionaries provided to 25 of 25 individuals (100%) were reviewed at least annually by the IDT as evidenced in the ISP.<br>• In 16 of 25 ISPs reviewed (64%) a description of how the individual communicated, including the AAC system if they had one, was included.<br>• Zero of 25 ISPs reviewed (0%) included how communication interventions were to be integrated into the individual's daily routine.<br>• Twenty-five of 25 ISPs reviewed (100%) contained skill acquisition programs to promote functional communication.<br>• Two of 25 ISPs reviewed (8%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. For the remainder, there was no evidence of review of data to assess whether there had been progress.<br><br><u>Individual-Specific AAC Systems:</u><br>There were 124 individuals living at DSSLC who were identified as having priority 1 or 2 severe language deficits. Per review of the AAC list provided by DSSLC, 195 individuals had AAC or EC devices. Many individuals had recommendations to utilize the common area devices but recommendations were vague and did not provide clear direction as to how and when individuals would utilize such devices. Another concern was that many devices were only utilized once or twice daily and this was normally in life skills classes. Devices were not portable beyond the area of life skills.<br><br>Personal AAC devices ranged from high tech (such as Dynavox) to low tech (communication books).<br><br>Observations were conducted in Houston Park, Cedar Falls, and various life skills areas on these apartments for individuals with AAC systems in Sample #4. Findings included the following:<br>• AAC systems for two of eight individuals (25%) were present.<br>• AAC systems for two of eight individuals (25%) were noted to be in use.<br>• Eight of eight (100%)AAC systems were portable but zero of eight individuals (0%) were noted to be utilized by the individuals.<br>• Eight of eight (100%)AAC systems were functional for the individual but again | Noncompliance |

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| | | not utilized.<br>• For three of eight individuals with AAC systems (37%), staff **i**nstructions/skill acquisition plans related to the AAC system were available.<br><br><u>General Use AAC Devices:</u><br>DSSLC had shared devices scattered throughout all homes and work environments.<br><br>General AAC devices were available in the common areas of most of the homes including Westridge, Timberhill, 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 consistently working and the Monitoring Team did not observe them to be utilized in any of the observations.<br><br>Observations were completed in Westridge, Timberhill, Houston Park, and Cedar Falls to determine the presence and use of general AAC devices. Findings included the following:<br>• Seven of the seven homes (100%) had general use AAC devices present in the common areas.<br>• Thirteen of the 21 general use AAC devices (61%) noted contained clear directives that were readily available (on wall, in notebook, etc.) on how staff should use these devices.<br>• Twenty-one of 21 general use AAC devices (100%) noted had a clear function within that setting/situation.<br>• Zero of 21 general use AAC devices observed (0%) were used by individuals during situations in which use of devices were appropriate (e.g. mealtime, bathing, going outside).<br><br><u>Direct Communication Interventions:</u><br>Overall, 18 individuals were receiving direct services by the SLPs at the time of the review. Direct communication-related intervention plans for individuals included in Sample #6 were reviewed.<br><br>Generally accepted practice standards for comprehensive progress notes related to communication interventions include:<br>• Contained information regarding whether the individual showed progress with the stated goal.<br>• Described the benefit of device and/or goal to the individual.<br>• Reported the consistency of implementation.<br>• Identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. | |

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| | | Documentation of SLP review for one of five individuals (20%) was comprehensive as per the indicators outlined above. The progress reviewed that were not comprehensive were missing the following:<br>• Described the benefit of device and/or goal to the individual.<br>• Identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress.<br><br>Overall, the individuals were not provided the direct services recommended by the IDT Examples of this include:<br>• Individual #566 was recommended for direct services 2-4 times per month. From 7/2/12 to 10/3/12, the individual only attended speech treatment 4 of 14 scheduled times (28%)<br><br><u>Indirect Communication Supports:</u><br>Programs for individuals who received indirect communication supports included in Sample #4 were reviewed.<br>• Quarterly documentation for zero of eight individuals (0%) contained information regarding whether the individual showed progress with the stated goal(s).<br>• Quarterly documentation for zero of eight o individuals (0%) identified the benefit of device and/or goal(s).<br>• Quarterly documentation for zero of eight individuals (0%) identified consistency of implementation.<br>• Quarterly documentation for zero of eight individuals (0%) identified recommendations/revisions to the program as indicated and related to the individual's progress or lack of progress.<br><br><u>Staff Interviews:</u><br>Findings from the eight staff interviews and observations conducted on Westridge, Timberhill, Houston Park, and Cedar Falls included the following:<br>• In three of eight interviews conducted (37%), direct support professionals stated whether the individual had an AAC system.<br>• In two of eight interviews conducted (25%), direct support professionals located the individual's communication equipment.<br>• In three of eight interviews conducted (37%), direct support professionals stated whether there was a communication program.<br>• In three of eight interviews conducted (37%), direct support professionals described the communication program goal. | |

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| | | • In zero of eight observations (0%), direct support professionals implemented the communication program as written.<br>• In two of eight interviews conducted (25%), direct support professionals showed where, when, and how data was recorded for the program.<br>• In one of eight interviews conducted (12%), direct support professionals described the schedule for implementation of the communication program.<br>• In four of eight interviews conducted (50%), direct support professionals identified how communication skills in the program were addressed throughout the day.<br>• In one of eight interviews conducted (12%), direct support professionals stated that they had received individual-specific training for the program and/or AAC.<br>• In zero of eight interviews conducted (0%), direct support professionals described individual-specific communication strategies as identified in the individual's PNMP, ISP, PBSP, and/or Communication Dictionary.<br><br><u>Competency-Based Training and Performance Check-offs:</u><br>Staff were provided with a class titled "Communication" during new employee orientation. All staff were required to participate in the class through group exercises (i.e., activation of devices). In-service training was provided by the SLPs upon the introduction of a new communication system and return demonstration of implementation was required. There was no annual refresher provided related to communication.<br><br>While the interactions of staff with the individuals were generally positive, much of the interaction observed by the Monitoring Team was specific to a task, with little other interactions that were meaningful, such as during a meal. Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities (using assistive technology), should be made a priority. This will only be possible when the clinicians are sufficiently available to model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts.<br><br>Based on review of the NEO training curriculum and observations, direct support professionals, PNMPCs and therapy aides were provided with competency-based training related to communication.<br><br>New Employee Orientation and individual training included:<br>• Methods to enhance communication<br>• Implementation of programs<br>• Benefits and use of AAC | |

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| | | • Identification of non-verbal means of communication.<br>• Opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners.<br>• Adequacy of skill performance check-offs<br><br>As mentioned above, while the NEO training appeared to meet basic standards, missing from the process was the ability of Speech staff to have the needed presence at the homes to model and guide staff through real life activities and situations. | |
| R4 | Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually. | <u>Monitoring System:</u><br>The monitoring system consisted of periodic PNMP monitoring that included communication. These were generally conducted by the PNMPCs to check for availability, condition, and working order.<br><br>DSSLC did not have AAC Monitoring Policy that defined the following:<br>• Monitoring for the presence of communication adaptive equipment or other AAC supports/materials.<br>• Monitoring for the working condition of communication adaptive equipment.<br>• Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work).<br>• The frequency of monitoring. The policy stated that the level of monitoring would be determined by the SLP. This included direct treatment being reviewed for effectiveness at least every 3 months and indirect treatment with AAC to be reviewed at least quarterly and without AAC at least annually. This is not in line with current standards of practice and not sufficient to ensure appropriateness of device or treatment, nor was it adequate to ensure implementation of communication strategies and devices.<br>• The process for identification, training, and validation for monitors.<br>• The process of inter-rater reliability.<br>• A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic).<br><br>At the time of the review, DSSLC did not have a process or database in place that tracked the indicators listed below:<br>• Frequency per recommendations<br>• Present<br>• Working order<br>• In use throughout the day | Noncompliance |

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| | | • In the case a problem was identified, there was evidence of resolution<br><br>Refer to Provision R.3 for information regarding effectiveness monitoring. | |

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

1. Review, and revise as determined appropriate, Communication Services Policy CMGMT-23. (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 communication strategy and AAC device is meaningful to the individual and the individual can communicate and be an active participant in multiple environments (Provision R.3).
3. All individuals provided with an order to receive direct Speech services should receive such services (Provision R.3)
4. Staff would benefit from increased hands on modeling of the use and integration of devices with normal daily contexts by the PNMPCs and the SLPs. (Provision R.3)
5. Communication Goals should be followed by the SLP at a level that allows for consistent review of progress with goals and objectives. (i.e., at least on a monthly basis if service is direct and quarterly if indirect). (Provision R.2)
6. Communication Assessments must do a better job at identifying methods to enhance communication in the contexts of a 24 hr day. (Provision R.1)
7. A monitoring system needs to be developed that outlines the frequency in which the presence and working condition of devices will be tracked as well as frequency for effectiveness monitoring by a licensed speech therapist (Provision R.4)

| SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs | |
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| 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:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment 9/24/2012<br>2. DSSLC Action Plan 9/24/2012<br>3. DSSLC Presentation Book for Section S<br>4. DADS Draft Policy 017: Habilitation, Training, Education and Skill Acquisition Programs 6/20/12<br>5. Documents that were reviewed included -- where available -- 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 Individuals #116, #182, #416, #502, #686, #697, and #740.<br>**People Interviewed:**<br>1. Linda Ford – Director of Active Treatment<br>2. Trent Lewis – Vocational Services Director<br>3. Pung Nelson – Director of Life Skills Program<br>4. Randy Spence, MS – Director of Behavior Services<br>5. Jill Wooten, MS, BCBA – Psychologist<br>6. Laura Dittlinger-Harper, BCBA - Consultant<br>7. Approximately 20 direct care staff in the following residences and day treatment areas: Residence 512, 502B, 502C, 502D, 508A, 522A, 522B, 522C, 522D, 523B, 523C, 523D, 525A, and525B, as well as training area ICD 121, ICD 124, and ICD 128.<br>**Meeting Attended/Observations:**<br>1. Positive Behavior Support Committee – 10/10/2012<br>2. The following residences and day treatment areas: Residence 512, 502B, 502C, 502D, 502D, 508A, 522A, 522B, 522C, 522D, 523B, 523C, 523D, 525A, and525B, as well as training area ICD 121, ICD 124, and ICD 128. |
| | **Facility Self-Assessment:**<br>The Facility submitted a Self-Assessment for Section S_. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating.<br><br>For Section S, in conducting its self-assessment, the Facility:<br>• Did not report or identify specific monitoring or auditing tools. The Self-Assessment made reference to a "monitoring tool", and included a sample of the monitoring tool in material submitted to the monitor. The Facility did not, however, present information in the Self- |

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| | Assessment as to how the tool was used to obtain ratings. It was important to know that the Monitoring Tool had been used. It was not sufficient, however, to state only that the Monitoring Tool had been used. For monitoring of any kind to be meaningful, there should also be information regarding the number of records reviewed using the tool, the conditions under which monitoring was conducted, how comparisons were made, and how the tool lead to specific findings or conclusion. As this information was not present in the Self-Assessment, it would be beneficial for DSSLC to incorporate such information in future reviews.<br>• Did not provide information regarding outcome measures and indicators in a manner that was helpful to the Self-Assessment process. The Facility did present percentages in regard to engagement, assessments completed, the number of outings, and the number of outings where SAPs/TDRs were implemented. As indicated above, however, it was not clear from the Self-Assessment how these percentages and other data had been calculated. Without contextual information, such as sample size, procedural information, or supporting documentation, it was not possible to determine if the information presented by the Facility was accurate, reliable, or meaningful. Due to these limitations, it was not possible to determine if the Self-Assessment document contributed to the assessment of progress.<br>• The Facility consistently did not present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment:<br>o Did not present findings consistently based on specific, measurable indicators. Although the Self-Assessment included statements such as "data", the numbers and percentages presented were not consistently tied to a measurement process. For example, the percentage of compliance was reported for several sequential months. There was no definition, however, of compliance and no discussion or interpretation was included by the Facility.<br>o Consistently did not measure the quality as well as presence of items.<br>• The Facility rated itself as being in compliance with no provisions of Section S._<br><br>The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance.<br>• All actions were reported as In Process except for the use of corrective action plans regarding "Community Outings" which was described as Not Started.<br>• The Facility data did not identify areas of need/improvement.<br>• The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. Rather, the Facility provided a variety of discrete actions. As these actions were presented in very general terms and lacked measurement criteria, it was not suggested that these actions were likely to lead to substantive changes or improvements.<br><br>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. |

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| | **Summary of Monitor's Assessment:**<br>Observations, interviews, and record reviews were conducted on-site at DSSLC from 10/8/2012 through 10/12/2012. 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.<br><br>There were areas noted during observations and record reviews that suggested progress. In both circumstances, however, mitigating factors lessened the importance of the progress.<br>• Data regarding engagement suggested that improvement had been achieved in the provision of meaningful engagement. This improvement, however, consisted of a return of engagement to levels noted prior to the April 2012 site visit. There was no indication of substantial improvement in comparison with baseline conditions from the first site visit.<br>• Reports suggested that the Facility had placed greater emphasis upon providing skill acquisition training. Although data suggested that more community outings including skill acquisition training, no actual data from community training were presented.<br><br>DSSLC had improved in ensuring that individuals were provided with meaningful activities since the last compliance visit, returning to levels found during the September 2011 visit. 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. However, several settings failed to provide a minimal level of engagement.<br><br>During the current site visit, DSSLC was asked to provide an example from each of the seven units that reflected the best work in developing SAPs through the ISP process. This example was to include the ISP, the FSA, and assessments from other disciplines and clinicians. None of the five examples (0%) included all relevant assessments associated with the ISP process. Without the requested assessments and other documentation, it was not possible to determine whether individuals were provided with the necessary annual assessments.<br><br>The Facility also reported that arrangements had been made for a BCBA to provide training and monitoring services related to skill acquisition programs. The consultant BCBA had only just begun providing services, so it was not possible to measure specific benefits. Nevertheless, it was noteworthy that the DSSLC had arranged for assistance in this area.<br><br>Of greatest concern during the current site visit was the need for the Facility to provide the documentation necessary to assess progress. It was not possible for the Monitoring Team to determine progress toward compliance for several Provisions in Section S due to the need for complete and accurate supporting evidence. Without supporting documentation, neither the Monitoring Team nor the Facility can effectively determine that Individuals living at the Facility are provided the essential services. DSSLC must act with greater diligence to ensure that objective and accurate measures are obtained so that both service provision and progress toward compliance can be measured. |

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| S1 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized 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. | Use of Assessment Information in Planning Skill Acquisition<br>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.<br><br>Historical Perspective<br>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.<br><br>During the April 2012 site visit, 13 individuals were selected by the Monitor in order to compare Skill Acquisition Programs (SAPs) with relevant assessments. The findings of the April 2012 review provided very few examples that reflected the integration of assessments into the ISP process or SAPs.<br><br>Current Site Visit<br>During the current site visit, DSSLC was asked to provide an example from each of the seven units that reflected the best work in developing SAPs through the ISP process. This example was to include the ISP, the Functional Skills Assessment (FSA), assessments from other disciplines and clinicians, SAPs, data collection forms for the SAPs, data graphs, and SAP progress notes. Although the Facility did provide example material from each of the seven units, for none of the units was the material complete. Of the material that was presented by the Facility, only one example (20%) included all SAPs and monthly SAP data sheets. None of the five examples (0%) included all relevant assessments associated with the ISP process. Although some examples included progress notes and graphs, these progress notes lacked dates, narratives, and indications of which SAP was the focus of the note or graph.<br><br>Without the requested assessments and other documentation, it was not possible to complete a review of the use of assessments in the development of SAPs. Furthermore, the lack of SAPs and data forms prevents a review of the quality of SAP content.<br><br>Implementation of formal and informal skill acquisition training<br>Historical Perspective<br>During all previous site visits, pervasive problems were noted regarding the implementation of skill acquisition programs. Only in very limited circumstances had staff | Noncompliance |

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| | | been observed to implement formal training or offer prompts and reinforcement in the manner prescribed by the skill acquisition programs.<br><br>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.<br><br>During the April 2012 site visit, 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.<br><br><u>Current Site Visit</u><br>During the current site visit, observations were conducted in a variety of settings across the DSSLC campus in order to assess engagement and SAP 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 121 | 3 | 4 | 3 | 75% |
| ICD 124 | 3 | 7 | 4 | 57% |
| ICD 128 | 11 | 17 | 17 | 100% |
| 512 | 3 | 10 | 6 | 60% |
| 502D | 2 | 3 | 1 | 33% |
| 502D | 1 | 1 | 1 | 100% |
| 502C | 1 | 4 | 1 | 25% |
| 502B | 2 | 6 | 2 | 33% |
| 522B | 1 | 7 | 1 | 14% |
| 522D | 3 | 6 | 2 | 33% |
| 522C | 5 | 9 | 5 | 56% |
| 522A | 2 | 8 | 7 | 88% |
| 523B | 2 | 6 | 1 | 17% |

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| 523C | 4 | 9 | 9 | 100% |
| 523D | 3 | 7 | 2 | 29% |
| 525A | 2 | 4 | 4 | 100% |
| 525B | 1 | 2 | 2 | 100% |
| 508A | 2 | 6 | 1 | 17% |
| | 51 | 116 | 69 | |
| Total percentage of individuals functionally engaged | | | | 59% |
| Percentage of locations with greater than 50% functional engagement | | | | 58% |

Based upon the observations conducted during the current site visit, it was evident that overall functional engagement had increased from 33% to 59% of individuals. Furthermore, 10 of the 18 observed locations (58%) reflected functional engagement at or above 50% of individuals. These data suggested that DSSLC had improved in ensuring that individuals were provided with meaningful activities since the last compliance visit, returning to levels found during the September 2011 visit.

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 classroom 124, individuals were provided a variety of materials and activities. Several staff were observed engaging in informal teaching, such as using hair and clothing to prompt color recognition. On individual exhibited verbal agitation toward a particular staff member during the observation. The supervising staff quickly rotated a different staff in as a replacement. The new staff continued the previous activities and the agitation dissipated.
- In Apartment 512, chapel services involving live guitar music was observed. The musician rotated attention amongst the individuals attending the service while other staff interacted with individuals by offering choices and discussing the music.

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 improved from the previous site visit in terms of engagement and not placing Individuals at risk. Nevertheless, several settings failed to provide a minimal level of engagement.

- In Apartment 522C materials were present and a staff was bouncing a ball, but no individuals were engaged in activities. One individual was moving a single block on a table. Staff verbally prompted individuals four times to wash hands for dinner. No hand washing was observed, but the prompting staff reported to other staff that hands were washed.

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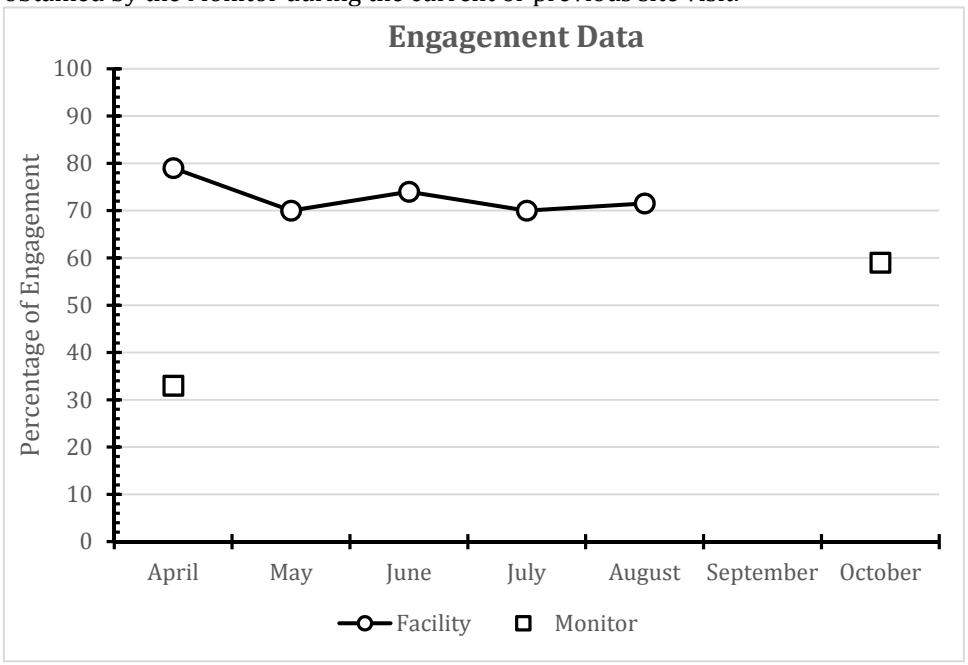
| | | • In Apartment 522D individuals were moved to dining tables with minimal interaction or prompting. Staff reported that hands were clean although no hand washing was observed and individuals were noted to have touched multiple objects and surfaces while waiting for the meal. One individual had instructions to be observed for rumination during meals. Staff seldom attended to the individual and no overt scrutiny for rumination was noted.<br>• In the Apartment 502D living room, a Dr. Phil television program about marriage and family discord was on the television. No individuals were attending. One individual was asleep, one individual was sitting in front of a visual stimulation device, and a third individual was lying in a bed with no activity or interaction. Two staff was present in the room.<br>• In several apartments it was observed that individuals were moved to bedrooms immediately following evening meals while staff congregated outside.<br><br>DSSLC staff reported that audits of engagement were conducted. Documentation provided by the Facility reflected engagement ratings of between 70% and 79% between April and September 2012. As the graph below reflects, the Facility ratings were higher than those obtained by the Monitor during the current or previous site visit.<br>  <br> | |

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| | | It was not evident in the documentation provided by the Facility how many observations had been conducted by DSSLC. Without information regarding the number of observations, it was not possible to assess the quality of Facility engagement data It was noted, however, that ratings obtained by the Monitor were lower and suggested improvement while Facility ratings were higher and reflected greater stability.<br><br>Despite the lack of SAP and assessment examples, as well as circumstances involving poor engagement and a lack of skill training, there was some positive growth noted at DSSLC. The Facility reported that a BCBA, Laura Dittlinger-Harper, had agreed to provide training and SAP monitoring at the Facility. As this program was relatively new, only initial training regarding prompting and data collection had been provided. It was indicated by Ms. Dittlinger-Harper, however, that future plans included competency-based training and on-going review of a sample of SAPs each month.<br><br>Based upon data collected from observations and record reviews during the current site visit, it was unclear how well the Facility could monitor functional engagement or ensure that individuals were provided with active treatment. Furthermore, the failure by the Facility to provide examples of SAPs prevented a review of skill acquisition program quality. Without the means to assess either formal or informal services, it was not possible to determine if DSSLC had achieved 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. | <u>Historical Perspective</u><br>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 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.<br><br>During the April 2012 site visit, records were reviewed for 13 individuals living at DSSLC. That review revealed no 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. | Noncompliance |

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| | | Current Site Visit<br>During the current site visit, DSSLC was asked to provide an example from each of the seven units that reflected the best work in developing SAPs through the ISP process. This example was to include the ISP, the FSA, and assessments from other disciplines and clinicians. None of the five examples (0%) included all relevant assessments associated with the ISP process.<br><br>Without the requested assessments and other documentation, it was not possible to determine whether individuals were provided with the necessary annual assessments. It was reported by the Facility that 59% of assessments were not completed in time for the ISP meeting. This suggested that, even when assessments were performed, in the majority of circumstances it was not possible to integrate assessment findings into the ISP process. | |
| 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 not possible to determine if training programs addressed pertinent needs of the individual. Based upon the lack of documentation, it was not possible to determine if the Facility had progressed substantially beyond baseline conditions. | Noncompliance |
| | (b) Include to the degree practicable training opportunities in community settings. | Historical Perspective<br>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. By September 2011 site visit, however, the Facility had reinvigorated the community activities process with a substantial increase in outings. A modest downward trend was noted in April 2012, although total number continued to remain at reasonable levels. | Noncompliance |

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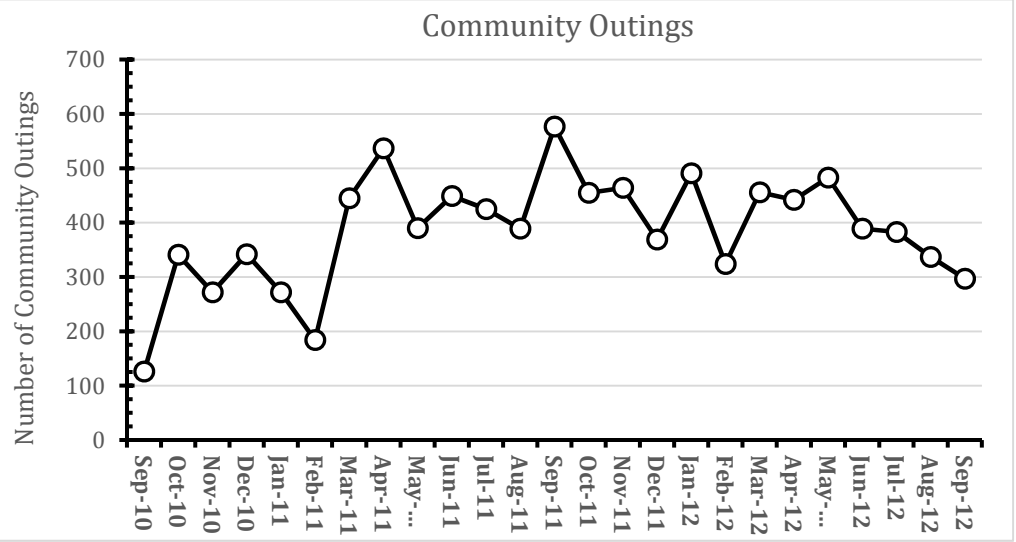
| | | Current Site Visit<br>During the current site visit, data revealed that community outings have remained at relatively high levels.<br>  <br><br>This provision of the Settlement Agreement addresses not only the quantity of community opportunities, but the provision of training in the community as well. During previous site visits, it was reported that many community outings included the implementation of SAPs, but that a system to track community training did not exist.<br><br>During the current site visit, there was a noted decline in the number of outings. The Facility reported, however, that the emphasis had shifted from the total number of outings provided toward providing formal skill acquisition training in the community. In addition, the Facility reported that a system had been developed to track SAP implementation in the community. The graph below depicts the reported change in emphasis and the resulting increase in community SAPs. The Monitoring Team asked DSSLC to provide an example from each of the five units that reflected best work in developing SAPs through the ISP process, to include the ISP, the Functional Skills Assessment (FSA), assessments from other disciplines and clinicians, SAPs, data collection forms for the SAPs, data graphs, and SAP progress notes. Although the Facility did provide example material from each of the five units, for none of the units was the material complete. Of the material that was presented by the Facility, only one example (20%) included all SAPs and monthly SAP data sheets. None of the five examples (0%) included all relevant assessments associated with the ISP | |

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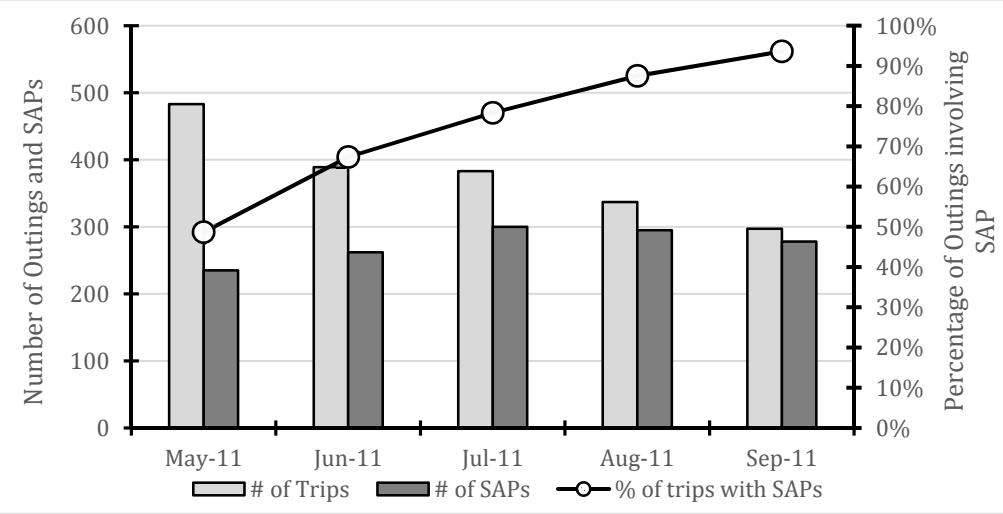
| | | process. Although some examples included progress notes and graphs, these progress notes lacked dates, narratives, and indications of which SAP was the focus of the note or graph. As complete records were not provided for the examples, it was not possible to determine if the quality of the SAPs was commensurate with the quantity.<br>  <br><br>Some changes were noted in community employment for individuals living at DSSLC. During the September 2011 site visit, 11 individuals were employed in the community. In April 2012, that number had dropped to eight individuals with community jobs. During the current site visit, the number of individuals in competitive employment had increased to nine.<br><br>It was positive to note that the Facility had made efforts to improve meaningful skill acquisition in the community. Without supporting documentation, however, it was not possible to determine that DSSLC had progressed substantially beyond baseline conditions. | |

**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 strengthening 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** | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. Denton State Supported Living Center (DSSLC) Self-Assessment, updated 09/24/12<br>2. Denton State Supported Living Center Action Plans, updated 09/24/12<br>3. Denton State Supported Living Center Report for Monitors, dated October 8, 2012<br>4. Section T Presentation Book materials<br>5. DADS Policy 018: Most Integrated Setting Practices, 3/30/10<br>6. Draft of updated DADS Policy 018: Most Integrated Setting, undated<br>7. Draft of DADS Policy 004: Individual Support Plan Process undated<br>8. Since last on-site review, a list of all individuals who have requested community placement, but have not been referred for placement<br>9. Since last on-site review, a list of all individuals who have been referred for placement<br>10. 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"<br>11. Discharge packets for individuals whose discharge may be classified as an "alternate discharge": Individual #537<br>12. Since last on-site review, a list of all individuals who have died after moving to community living<br>13. A current list of all alleged offenders committed to the Facility following court-ordered evaluations<br>14. For the last twelve months, a list of individuals who were reported to have been assessed for placement<br>15. Community Placement Report, dated Monday, October 08, 2012<br>16. For the last twelve months, lists of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices<br>17. Draft Analysis of Sep 7, 2012 Provider Fair Survey Responses<br>18. DSSLC Newsletter, The Grapevine, dated September 2012<br>19. On the Job Training: Transitional Specialist<br>20. Transition Specialists Meeting Agenda, dated October 10th and 11th<br>21. Transition Specialist Information brochure<br>22. Annual Report: Obstacles to Community Transition, Fiscal Year 2011, Data as of 8/31/2011<br>23. Obstacles Database<br>24. Quarterly Community Placement Obstacles reports |

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| | 25. Inclusion of the Designated Local Authority during Living Options Meetings (adopted 5/03/2012)<br>26. Since last on-site review, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed<br>27. Local Authority (LA) Community Living Options Information Process (CLOIP) Worksheets for Individuals #80, #102, #113, #164, #169, #224, #231, #520, #549, #609, #633, #637, #690, #702, and #705<br>28. List of Individuals with ISPs held June-September 2012<br>29. Individual Support Plans (ISPs) and Preferences and Strengths Inventory (PSI) for Individuals #56, #101, #211, #232, #250, #352, #371, #627, #741, and #750,<br>30. Denton State Supported Living Center Community Tour Documentation for Individual #56 and #306<br>31. Completed CLDPs for Individuals #258, #275, #493, and #505<br>32. Partial CLDPs for Individuals #183, #232, #238, #381, #512, and #627<br>33. CLDP Assessment Checklist, undated<br>34. Pre Move Site Reviews for Individuals #258, #275, #287, #354, #493, #494, and #505<br>35. LA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for Individuals #258, #275, #287, #354, #493, #494, and #505<br>36. Completed Post Move Monitoring (PMM) checklists for Individuals #258, #275, #287, #354, #493, #494, and #505<br>37. DSSLC PMM Protocol for providing PMM services for other SSLC, undated<br>38. ISP Monitoring Tool<br>**People Interviewed:**<br>1. Clark Clermont, Director of Community and Family Relations (CFR)<br>2. Leslie Clark, QDDP Coordinator<br>3. Frank Padia, Facilitation Coordinator<br>4. Jodi Vicars-Nance, Admissions/Transition Coordinator (ATC)<br>5. Tawasky Jones, Placement Coordinator<br>6. Laurie Cross, Post-Move Monitor<br>7. Eileen Short, Transition Specialist Coordinator<br>**Meeting Attended/Observations:**<br>1. ISPs for Individuals #250, #750<br>2. Post-Move Monitoring Visit for Individual #493<br>3. Meeting between Department of CFR and Contract LA |
| | **Facility Self-Assessment:**<br>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.<br><br>**For Provision T1**, the Facility indicated it was not in full compliance with his provision, but it did report it |

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| | had achieved some level of compliance in a number of component areas. Those included:<br>• Provision T1c2: Specify the SSLC staff responsible for these actions, and the timeframes in which such actions are to be completed;<br>• Provision T1c3: 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;<br>• Provision T1d: Each SSLC shall ensure that each individual leaving the SSLC to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving;<br><br>The Monitoring Team concurred with the Facility's assessment in Provisions T1c2 but did not find substantial compliance with the remaining provisions.<br><br>The Monitoring Team noted that in many cases, the Facility relied heavily on completed Section T monitoring tools to assess its own compliance rating. These audits were generally reported to yield compliance score of 90-100%, which were not consistent with the Monitoring Team's findings. The Monitoring Team urges the Facility to further examine the deficiencies in the Monitor's reports and to use these to continue to refine and develop its own critical outcome indicators based on its own strengths, needs and experiences.<br><br>**For Provision T2**, the Facility self-rated substantial compliance in Provision 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 the one death that occurred in the community. The Monitoring Team continues to urge 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 Provision T2b, as it addresses the Monitoring Team's on-site verification of the Facility's PMM processes. Noncompliance was also found for this provision.<br><br>**For Provision T3,** no compliance rating is required.<br><br>**For Provision T4,** The Facility rated itself as being in substantial compliance and the Monitoring Team concurred.<br><br>The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. The ongoing action steps laid out did address many of the concerns found during this monitoring visit, such as:<br>• Enhance the review process by the IDT of Post Move Monitor (PMM) visits;<br>• Use QA data to provide feedback to the PMM;<br>• Develop a new community tours plan; and,<br>• Train IDT members on the need to develop community integration action plans for all individuals. |

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| | The Monitoring Team concurs that the successful accomplishment of these actions would likely contribute to compliance with the some requirements of this Section. However, the devil is in the details; the Monitoring Team recommends that these action steps be further operationalized with clear criteria to determine if the actions are producing the desired results. This is based on a review of action steps that have been identified as completed, yet have not had a significant impact on outcomes, as evidenced by the findings in this report. These included:<br>• Implement identification of obstacles in the ISP process;<br>• Provide training to IDT members on Olmstead requirements for assessment recommendations and living option discussions;<br>• Complete a list of services that provides IDT members a comparison of DSSLC services and HCS services; and,<br>• Develop list to assist IDT members in the CLDP process to review and develop action plans toward resolving barriers and obstacles to community living. |
| | **Summary of Monitor's Assessment:**<br>This Section was found to be not in compliance overall. A summary of noted progress included: Transition staffing was in the process of being augmented by two new Transition Specialist positions which should enhance education and awareness of community living options as well as increase the pace of transitions once a referral is made. The Facility had initiated a project to enhance both timeliness and adequacy of assessments to address one of its most significant deficiencies which appeared to hold promise for improvement in this area. DSSLC had also developed a protocol, as recommended during the previous site visit, to be followed that 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 laid out procedures to ensure there would be close communication between SSLCs to facilitate IDT review and recommendations. Other specific findings are detailed below:<br><br>**For Provision T1,** nine individuals had transitioned to community living and there were 16 active referrals. The Monitoring Team found substantial compliance in Provision T1c2 which addressed the identification of Facility staff responsible for required CLDP actions. 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 their 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. The Monitoring Team was encouraged by the emphasis the Facility leadership was placing on the assessment process in general and recommends this emphasis be expanded to address CLDP assessments. |

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| | **For Provision T2**, the Facility reported it was in compliance with Provision T2a, but the Monitoring Team did not concur. The Monitoring Team found that the PMM Checklists were completed in a timely manner, but DSSLC did not yet consistently provide an adequate assessment of the presence of supports called for in the CLDP. In fact, there was slippage noted in the implementation of the PMM processes from previous reviews. Adverse outcomes were reported for four of seven individuals who transitioned during this six month period. The Monitoring Team urges the Facility to use the adverse events to examine how it may improve its own CLDP and PMM processes. Given the number, and in at least one case severity, of the adverse outcomes, the Monitoring Team recommends an additional layer of review and scrutiny be given to CLDPs before approval and to the subsequent PMM over the course of the next six months.<br><br>**For Provision T3**, no rating is required.<br><br>**For Provision T4**, the Facility was in substantial compliance. The Facility reported one Alternate Discharge during the past six months, and it appeared to have been completed in compliance with CMS discharge planning requirements and DADS policy. |

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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 | Transition Outcomes During Last Six Months:<br>• Community Transitions: There were nine transitions to community living between April 2012 and October 2012.<br>• Referrals for Community Transitions: DSSLC had 16 active referrals in process, according to the Community Placement Report.<br>• Adverse Outcomes Related to Transitions: There had been some significant adverse outcomes for individuals who had moved to the community in the past six months, including one death.<br>o Returns from Community Placement: There were no returns from a community placement during this six month period.<br>o Deaths Following Community Placement: There was one death of an individual following a community placement that occurred during this six month period. The death occurred shortly after the completion of the 90-day PMM period.<br>o Psychiatric hospitalizations: Individual #494 had a psychiatric hospitalization during the first 45 days after transition. His IDT requested that he continue to receive post-move monitoring for a period of six months.<br>o Unauthorized Departure/Police Contact/Transferred to a Different Setting: There was no police contact for any individual during this six | Noncompliance |

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| | the State, the resources available to the State, and the needs of others with developmental disabilities. | months.<br>o Emergency or unexpected medical hospitalizations: Two individuals had unexpected hospitalizations within 90 days following community transition during the past six months. One of the individuals was hospitalized on two occasions. Both individuals were treated for a UTI and one was also treated for aspiration pneumonia.<br><br>It is notable that four of the seven individuals who had transitioned in the past six months had experienced some adverse outcome. The Facility should use these data to continually evaluate and improve its CLDP and PMM processes.<br><br>Actions Taken to Encourage and Assist Individuals to Move to the Most Integrated Setting:<br>During this past six months, DSSLC had taken some steps that were intended, at least in part, to assist IDTs to more effectively implement their responsibilities to encourage and assist individuals to move to the most integrated settings appropriate to their needs. Examples included:<br>• A new Facilitation Coordinator position had been created to focus on QDDP training.<br>• There had been substantial ongoing training to QDDPs in the development of appropriate ISPs, including some emphasis on how to facilitate the discussion around most integrated setting.<br>• The Facility had hired two Transition Specialists funded by the State's Money Follows the Person grant. This is discussed in more detail in Provision T1b2 below.<br><br>Conclusion: This provision was found to be not in compliance. The Monitoring Team commends the activities and initiatives described above. As detailed in the rest of this Section T and in Section F above, however, outcomes in the areas of assessment and planning for protections, services and supports (see Provisions F1c, F1d, F1e, F2a1 and F2ab); education for community awareness (see Provision T1b2); and transition and discharge planning (see Provisions T1c1, T1d, and T1e) indicated the Facility could not yet be said to be effectively assisting and encouraging individuals to move to the most integrated setting. | |
| 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 | Status of Policies and Procedures:<br>The Facility reported that it had made no changes to transition and discharge policies. An updated DADS Policy 018: Most Integrated setting was pending. The Monitoring Team completed a review of the draft policy with the following observations:<br>• Requirements for the provision of adequate education about available | |

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| | policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that: | community placements for individuals and their families to enable them to make informed choices had been significantly expanded, including that the ISP provides for the IDT to follow up to determine the individual's reaction to the educational activities offered, and that the APC must, in conjunction with the Facility's administrative team, establish a plan to promote and encourage exposure to alternate living environments for Facility staff.<br>• The policy indicated the living options discussion should include a number of key elements. Among these were 1) the supports and services needed by an individual for transition to an alternate placement or to remain in the State Center, and 2) the essential and non-essential supports and services for the individual that must be secured if an alternate setting is to be chosen by the individual and/or the LAR.<br>• There was a requirement that the IDT convene every 30 days following the initial 180 day timeframe after a referral was made to discuss an obstacles to transition and identify plans/strategies to overcome those obstacles.<br><br>A draft of a revised DADS Policy 004: Individual Support Plan Process was also reviewed. This policy outlined the updated ISP format and process which included the living options discussion.<br><br><u>Status of Process and Training on ISP Development:</u><br>Over the past six months, DSSLC had provided some additional training on topics related to ISP development. As noted in Provision T1a, the Facility had been providing ongoing training to QDDPs and IDT members as to the requirements and processes contained in the existing statewide policies. As reported in Provision F2e, the QDDPs and IDTs had also received training in the updated ISP process, including the Living Options portion.<br><br>At parties' meetings in July 2012, the parties agreed that the Monitors would rate T.1.b as just the development of an adequate policy. The sections T.1.b.1 through T.1.b.3 would be considered stand-alone provisions that require implementation independent of T.1.b or any of the other cells under T.1.b.<br><br>Due to the fact that the State and Facility had not yet finalized an adequate policy related to transition and discharge processes, the Facility remained out of compliance with this provision.<br><br>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. | |
| | 1. The IDT will identify in each | <u>Status of Process and Training on ISP Development:</u> | Noncompliance |

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| | individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles. | The Facility had begun to implement the most recent statewide modification to the ISP process. The Monitoring Team was asked to focus primary attention on two ISPs held during the site visit as an indication of the direction the Facility was pursuing. As discussed further in Provision F1e, throughout Provision F2, and below, these early examples did not reflect any significant progress. Consultants continued to provide training on this new process, but additional training was still 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.<br><br><u>Identification by the IDT of Protections, Services, and Supports That Need to be Provided in the Most Integrated Appropriate Setting:</u><br>As it relates to this provision, there was little progress demonstrated in the ability of the IDTs to identify 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. This was observed to continue to be true in the new ISP process and may be attributed in part to a sequence that did not ask the team to actually determine the most integrated appropriate setting until after the individual's services and supports had been identified. This tended to perpetuate the tendency of the teams to focus primarily on the supports and services currently being provided at the Facility. While such an array may include many essential services and supports, it does not take into adequate consideration the varied needs that may be needed for successful transition and community living. There must be an independent determination of the most integrated setting appropriate to an individual's needs, and the IDT must also identify the supports, services and protections that would be needed in that setting even if the IDT ultimately chooses not to make a referral. The process of identifying the needed supports and services is integral to determining whether a setting would be appropriate, and also serves to assist the individual and LAR to visualize how community living could be safely supported. The identification of needed services and supports is also pre-requisite to assisting the team to identify and address potential obstacles.<br><br>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 | |

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| | | proportion of individuals living at DSSLC had opportunities to tour community living options, and the annual CLOIP process was not meaningful for most. The PSI, which was 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 PSIs reviewed during this compliance visit provided little in the way of a visioning of an individual's ideal living arrangement. 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. 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.<br><br>Preferences of LARs and families for living arrangement were typically 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 F1e.<br><br>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.<br><br><u>Identification of and Plans to Overcome Obstacles to Transition:</u><br>DSSLC gathered obstacle information through the ISP process, and categorized these using a list of DADS-approved obstacles. These included:<br>• Individual's reluctance for alternate placement<br>• LAR's reluctance for alternate placement<br>• Lack of supports for people with significant challenging behaviors<br>• Lack of availability of specialized therapy supports<br>• Lack of availability of specialized medical supports<br>• Lack of funding due to an individual's legal and citizenship status<br>• Lack of specialized mental health supports<br>• Need for environmental modifications to support the individual<br>• Need for services and supports for persons with forensic needs/backgrounds<br>• Lack of specialized educational supports<br>• Need for transportation modifications to support the individual<br><br>The lack of presence of an LA representative at the ISP meeting was no longer to be considered an obstacle to a referral being made. The revised process called for the IDT to proceed with the referral, ensuring that the LA was notified within three business | |

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| | | days. If there were any questions or concerns on the part of the LA, a meeting with the IDT was to be held within two weeks of the referral.<br><br>Overall, the Monitoring Team found that obstacles to transition were not yet appropriately identified or addressed by the IDTs. In a review of 10 recent ISPs, including the two new ISPs, two resulted in a referral. Zero of eight (0%) of the ISPs reviewed in which a referral was not made evidenced proficiency in identification and addressing of obstacles. In many cases, the IDTs identified issues or resources that would be available in the community, indicating additional education for IDT members is required. For example:<br>• In a new ISP for Individual #750, the following as obstacles were identified: The two obstacles identified at this time are guardian's concern of community providers not able to provide a less restrictive living option for (the individual) due to medical issues and the lack of adequate medical supports in the community especially in a foster home environment. Other obstacles identified by the PST included 24 hour licensed nursing care; due to close monitoring seizure activity, episodes of pneumonia, care of G/J tube, monitoring of chronic health needs by a physician and professional consultants as needed; interventions through a PNMP to promote body alignment, skin integrity, mobility, and nutritional status; medical care to be immediately available; significant support in daily care activities, including assistance in all areas of personal hygiene including bathing, dressing, suction tooth brushing, grooming and toileting; assistance with medication administration; assistance in maintaining money and making purchases; assistance in scheduling appointments; assistance to follow daily schedule and to attend all appointments, securing transportation to and from appointments; uses a custom tilt in space wheelchair; would need a home that is wheelchair accessible and appropriate transportation; requires the use of a mechanical lift for safe transfers; a hospital bed with a therapeutic foam mattress for positioning to help prevent reflux and skin breakdown; a bathing table for her daily baths.<br><br>While the individual clearly had many and complex needs, it was also clear that many of these services and supports are available in the community and would not constitute a barrier. The IDT did not specifically address how the barriers could be resolved. The ISP indicated "(a) plan for addressing the first obstacle has already been created. Since some unanswered questions remain and must be answered to determine the exactly type and intensity of the medical services (the individual) will | |

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| | | require, a plan to overcome this obstacle will be created once the team has additional information. The most significant barrier at this time is respiratory care." The Monitoring Team understood the first obstacle referred to was guardian's concern of community providers not able to provide a less restrictive living option for (the individual) due to medical issues. Although there was discussion of the guardian's concerns in the narrative, as well as the guardian's potential openness to community placement in the future, there was no Action Plan developed related to this, either to explore community options that might meet the individual's needs or a plan to follow up with the guardian.<br><br>In none of the five (0%) that identified LAR or individual choice as the barrier were there specific action plans developed to address the barriers. In a few instances there were some general statements about tours and Provider Fairs, but no action plans resulted.<br><br>Conclusion: This provision was found to be not in compliance. As noted above with regard to Section F of the Settlement Agreement, although DSSLC had continued to make efforts to improve ISPs, the Facility remained out of substantial compliance with Sections F.1.d, F.2.a.1, and F.2.a.3. Additional details are provided in the sections of this report that address these provisions | |
| | 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. | Provision of Adequate Education About Available Community Placements to Individuals and Their Families or Guardians to Enable Them to Make Informed Choices:<br>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:<br><br>An Individualized Plan For Each Individual: The Facility did not yet succeed in developing individualized plans for community education and awareness. There was little progress observed in the sample of ten recent ISPs reviewed, including two in the new ISP process. In the ISP process itself, the Monitoring Team found there continued to be little attention devoted to careful assessment of the individual's specific need for education in this area, even when lack of awareness was identified as an obstacle to movement. For none of the ten (0%) recently completed ISPs was there an individualized plan for increasing awareness of community living options that took into account the learning needs of the individual.<br><br>An Annual Provider Fair: The Facility had held its annual provider fairs on September 7, 2012. The Facility had distributed a survey to attendees and had completed a preliminary analysis of the data. Overall, staff, individuals and families indicated | Noncompliance |

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| | | overwhelmingly that the Fair was good or excellent. The data also indicated attendees would prefer an additional weekend Provider Fair and the Facility stated its intent to provide this by March 2013.<br><br>Regular SSLC Meeting With Local LAs: The Director of CFR reported he had re-initiated a regular monthly meeting with the Contract LA. A meeting was held during the site visit. In addition, he had re-initiated quarterly meeting with all the local LAs. An agenda and sign-in sheet for a meeting held 9-21-12 were available for review. Topics covered included admissions/referrals, post-move monitoring, the role of the Transition Specialists and the role of the Human Rights Officer.<br><br>Education About Community Options: As noted below, the primary means for education about community options was the CLOIP process; in addition, as noted in this provision, there was a provider fair and community tours but little progress in developing individualized community education plans.<br><br>There was little evaluation of the effectiveness of education about community options. With the exception of a preliminary data analysis related to the Provider Fair discussed above and a process to gather information (but not data) from community tours, DSSLC did not have a 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:<br>• IDT Action Plans: The Facility reported it was not collecting data regarding the implementation of ISP Action Plans for community awareness and education in order to ensure these receive sufficient priority by IDTs. It should develop a process to do so. Although IDTs are required to document progress and activity in the ISP monthly 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<br>• 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 15 CLOIP Worksheets for recent ISPs. For one of the seven (14%) in which the LA was permitted to engage the individual, the LA Service Coordinator was able to document the individual had any interest in or meaningful response to the materials or information being offered. In each of the remaining six reviewed, the LA Service Coordinator actually documented the individual did not seem to comprehend or attend to the material presented. 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. This was discussed during the meeting with the Contract LA during the monitoring visit | |

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| | | and it was reported the LA was in the process of developing additional materials.<br>• Community Tours: As described further below, the Facility did have a formal process for documenting the community tour process, although it was not considered by the Facility to be used in such a way as to yield much useful information at this time. There was not a consistent process in place to evaluate the available data.<br><br>Tours Of Community Providers: In the past six months, there were 14 community tours reported. There did not yet appear to be a consistent, formalized process in place at the Facility to fashion these tours as a part of an individualized community living awareness and education plan. Specific findings regarding community tours included:<br>• 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 count of approximately 40 individuals participated in CLOIP community tours, a number which is approximately eight percent (8%) of the population of the Facility. As this was the only vehicle for acquainting individuals with community programs prior to a referral being made, this did not appear to provide sufficient opportunities for the 492 individuals residing at the Facility to obtain enough experience about community living to form an opinion, much less participate in informed decision-making. The Facility should examine how it might expand on the CLOIP tour process to make more such opportunities available to individuals.<br>• 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.<br>• 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. Overall, the size of tours at the Facility appeared to be conducive to both individual learning and assessment of responses.<br>• Individual's response to tours assessed: DSSLC did have a process in place for making an assessment of an individual's response to the tour experience in addition to a more structured process for individuals who had been referred for transition planning. Staff accompanying individuals on tours were expected to complete a brief form entitled Community Tour Documentation that asked how | |

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| | | the individual reacted to the tour and for any staff comments about the program. 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. According to the Director of CFR, most staff documentation was brief and not very informative.<br><br>Opportunities Are Provided To Visit Friends Who Live In The Community: No evidence was provided as to the provision of such opportunities for individuals to visit friends who live in the community.<br><br>Education Provided In Various Venues: The Facility did hold self-advocacy meetings for adults and youth, but a review of the minutes for the past six months indicated there had been no focus on community living options. The Director of CFR also reported that had been attending meetings of the Family Association and speaking informally with family members.<br><br>A Plan For Staff To Learn More About Community Options: Some educational opportunities about community options had been provided through staff participation in community tours, community exploration activities for individuals, and transition related visits. During the six months since the last monitoring site visit, the Facility documented approximately 50 staff participating in such activities, including tours and visits. The Transition Specialist was in the process of creating a resource guide with information and photos of different community living options that staff will be able to review. Staff also had the opportunity to attend the annual Provider Fair on September 7, 2012 and the Facility documented 164 staff who took advantages of this.<br><br>Individuals And Families Who Are Reluctant Have Opportunities To Learn About Success Stories: The Director of CFR was beginning to work on the documentation of success stories and planned to publish some such stories in the DSSLC newsletter, The Grapevine.<br><br>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 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 | |

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| | | 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. The Facility should also consider how it can address each of the criteria in this provision to create a comprehensive coordinated plan for community living education and awareness. | |
| | 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 Pursuant to Transition and Discharge Policies and Procedures:</u><br>The Facility described its process for assessing individuals for community living as follows: "All individuals are assessed for community placement through the Living Options discussion. At this time, the team discusses the supports that would be required if the individual chose to move to a more integrated setting. All aspects of an individual's support services are discussed with prioritization given to their preferences. During this process the team discusses the awareness of the individual and/or LAR about living options that are available and the preferences they have for a specific option. The team will discuss what obstacles are identified as a barrier to a less restrictive setting understanding that obstacles to movement are supports that are not available in a less restrictive setting. This is done through the identification of supports and services needed by the individual in specific areas such as education about living options, living environment, day programming, transportation, OT/PT, speech, medical, behavioral, psychiatric and rights/restrictions. If the team identifies obstacles that are not addressed through the Individual Support Plan (ISP) itself, they are tasked to create action plans to remove the identified obstacle. Each professional staff required to attend the ISP must make a professional recommendation for the movement answering the question of whether the service could be delivered in a less restrictive setting. They must then make a recommendation based on the unique circumstances for that individual. Ideally, the individual, LAR, and team must all be in agreement about a recommended choice of living option. However, it is clear that an individual's or LAR decision is final in this area of service decisions."<br><br>The ISP format and process had been recently updated. It included specific sections for consideration of living options, specifically requiring 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. IDT members were not yet implementing this in an adequate manner. This is discussed in more detail in Provision F1e above. | Noncompliance |

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| | | The updated ISP format, which was in the very 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. IDT members were to provide a recommendation regarding the most integrated setting in their individual assessments, and this appeared to be occurring with increasing frequency. Team members did not always appear to have knowledge of the types and levels of services that could be provided in the community and cited as obstacles resources and services that are readily available in the community. This is discussed in more detail in Provision T1b1 above.<br><br><u>Percentage of Individuals Assessed as Required:</u><br>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. Issues that affected the adequacy of the assessment included:<br>• As described in Provision T1b1, there was little progress demonstrated in the ability of the IDTs to identify 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;<br>• The Facility often did not have an adequate basis for determining the preferences of individuals for living arrangements;<br>• Also described in Provision T1b1, 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;<br>• As described in Provision F1e, each discipline's ISP assessment needed to include an opinion/recommendation regarding community living. For the two new ISPs held during the monitoring visit, not all assessments included this recommendation. In most cases, a template statement in the assessment shell simply indicated that the professional opinion was based on the current services and support being provided at the Facility and did not take into account that any different services might be needed in the community.<br><br><u>Conclusion:</u> This provision was found to be not in compliance. The Monitoring Team found there was not an adequate formal assessment process that included a substantive interdisciplinary evaluation and discussion. This was consistent with the Facility's own evaluation of their assessment process. | |

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| 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:<br>There were no changes reported to policies related to the CLDP. The Department of CFR was responsible for coordination of the CLDP process, in collaboration with the individual's IDT.<br><br>Timeliness of Development and Implementation of CLDP:<br>The CLDP was to be initiated at the time of referral and was to be updated on an ongoing basis as circumstances required. Documentation indicated CLDPs were typically, although not always, initiated upon referral. In at least one instance, for Individual #306, it was noted the Facility had not followed up on an IDT referral on a timely basis.<br><br>The Monitoring Team also reviewed the Community Placement Report, dated Monday October 08, 2012. Seven of the 16 (43%) current referrals had exceeded the 180 days allowed in the current policy and pending revision. Six of the nine community placements had also exceeded 180 days from the date of referral. 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.<br><br>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. The Department of CFR should develop and monitor a tracking list of action steps that need to be implemented once a referral is made and make follow-up with IDTs to ensure timely actions when necessary. This should be accomplished in conjunction with the provision of the revised Policy 018 that requires the IDT to meet every 30 days once the initial 180 days has expired.<br><br>Development of CLDP in coordination with the LA:<br>A review of completed CLDPs indicated that four of four (100%) evidenced that the plan was developed in coordination with the responsible LA. In addition to 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 Provision T1e below.<br><br>Conclusion: Provision T1c as found to be not in compliance. Overall, the Facility continued to make progress in terms of balancing timeliness of completing a transition with a cautious approach toward selection of the best provider for an individual. However, there were a number of instances in which placements did not occur within the 180-day requirement, and in several of these the documentation did not reflect timely | Noncompliance |

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| | | action and follow-up. The Director of CFR should develop and monitor a tracking list and make follow-up with IDTs to ensure timely actions when necessary. Coordination with the LA 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 developed, primarily in the failure by the IDTs to adequately identify the appropriate essential and nonessential 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><br>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 (pre-move supports that must be in place at the time of the move) and non-essential (post-move required supports that may be put into place following the move) supports must begin by considering those things identified in the ISP. The IDT did continue to rely heavily on the ISP and the assessments associated with it to guide the identification of the essential and non-essential supports. This was problematic because IDTs did not yet demonstrate proficiency in overall needs assessment, the interdisciplinary process necessary to integrate the assessment findings into a comprehensive support plan, or the identification during the 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.<br><br>This general lack of proficiency in assessment and integrated planning translated into a CLDP that did not sufficiently identify the essential and nonessential supports each transitioning individual will need. Significant examples of the failure to integrate assessment findings into a comprehensive support plan in the most integrated setting included:<br>• Individual #505 died shortly after the 90 day PMM period. The Monitoring Team reviewed the Individual's CDLP, annual medical assessment, and addendum to the annual medical assessment, medical consultation reports, and integrated progress notes. The individual was diagnosed at the Facility with many diagnoses, including diabetes mellitus that required very close monitoring; high blood pressure and coronary heart disease that required close monitoring; chronic renal insufficiency that require specialized diet, and follow-up with a medical specialist; obstructive apnea that required the use of a device to help the individual breath while asleep, and close monitoring by staff; bilateral cataracts and recommended surgical intervention; several gastrointestinal issues, including gastritis, hemorrhoids, and diverticulosis, that | Noncompliance |

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| | | required close monitoring. The Monitoring Team noted several important, and concerning issues related to the development and implementation of the CDLP, and related supports and services provided at the Facility, versus what was determined necessary at the time of transfer to the community agency, and post move monitoring. These are documented in detail in Provision L1. Examples included:<br>o The individual was known to have significant cardiovascular disease, and the annual medical assessment commented on the need to monitor closely for chest pain, and other signs, and symptoms of cardiovascular disease. This was not adequately communicated to the provider agency.<br>o The Facility did not refer the individual for cardiology consultation, prior to discharge from the Facility.<br>• Individual #493 had significant disabilities requiring close attention and monitoring during waking hours and also was known to have episodic periods of sleeplessness. The CLDP did not adequately assess how this would impact the type of home needed in the community to meet these needs. The IDT failed to adequately address the individual's level of support needs and prepare the selected provider. The IDT chose a foster care home without sufficient capacity for 24 hour awake care. According to the foster care provider, the issue of sleeplessness was not well communicated; in fact the provider indicated she had inquired on more than one occasion about the issue and had been assured it was not something to be concerned about. The Monitoring Team notes that the foster home provider was making great efforts to provide the care needed and seemed to genuinely desire to provide a good home, but she did express concern about how to manage the many sleepless night the individual was continuing to have since transition. There was a real potential for this placement to fail if additional supports were not provided for awake staff at night. If the IDT had made an adequate assessment of the individual's needs, it may have considered an alternate setting with 24 hour awake staff or could have provided for additional staffing in the foster home, at least through a transition period.<br><br>The Monitoring Team also reviewed four CLDPs to determine if there were any specific recommendations as to opportunities for activities that that would be available in a community living option. Only one of the four (25%) had any recommendations as to opportunities for new skill development that might be presented in the community. Individual #258's non-essential supports included getting a public library card, taking computer classes and finding a church for choir participation. The Monitoring Team encourages the Facility to include more focus on such opportunities and to make specific recommendations as to how individuals may continue to learn these new skills<br><br>There was some progress noted in the description of the evidence that was required to | |

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| | | demonstrate a support was adequately in place. The teams more often identified evidence beyond written documentation than in the past, including observation and staff interview, but it still was seldom specified what the observation or staff interview should reveal. Sometimes this appeared to be self-evident, but in many cases it was not. This is important because the Post-Move Monitor cannot be expected to have expertise in every area; she must rely on the expertise of the team to explicitly define what he should observe and what staff should be able to explain about the supports to be provided.<br><br>Coordination of CLDP with provider staff: A review of completed CLDPs indicated provider staff were typically very involved throughout the CLDP process. There was 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. However, as described above, provider staff of at least one individual (Individual #493) had indicated they felt they had not received complete or accurate information.<br><br>Conclusion: This provision was found to be not in compliance. Given the number, and in at least one case severity, of the adverse outcomes, the Monitoring Team recommends an additional layer of review and scrutiny be given to CLDPs before approval and to the subsequent PMM over the course of the next six months. | |
| | 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:<br>For four of four (100%) completed CLDPs reviewed, the Facility consistently identified the Facility staff responsible for each of the essential and non-essential supports by name. It was clear which Facility staff had been assigned responsibility to monitor and/or follow up with the designated provider staff to ensure implementation and/or timeliness for each and every support.<br><br>Completion timeframes for needed actions identified: For four of four (100%) completed CLDPs reviewed, the Facility did consistently identify timeframes for completion for each of the essential and non-essential supports.<br><br>Conclusion: This provision was found to be in substantial compliance. | Substantial Compliance |
| | 3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting. | Review of CLDP with Individual and, as appropriate, the LAR:<br>A review of both completed and partial CLDPs indicated individuals participated in CLDP proceedings and that IDTs considered the responses of individuals to pre-selection visits in making selections of providers. However, review of these documents also indicated that families and LARs were not consistently kept informed and/or their input was solicited at appropriate steps throughout the CLDP process. Examples included: | Noncompliance |

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| | | • For Individual #183, there was little history of family contact and the documentation in the CLDP indicated a Disability Right Texas (DRT) advocate was involved in the community placement deliberations. At one point in the ongoing process, it was noted a sister had participated in a meeting by teleconference and expressed some concerns, which the team attempted to address. The call abruptly ended before the meeting concluded and there was no further indication of attempts to involve the sister in the succeeding deliberations, provider interviews and trial visits.<br>• For Individual #232, it was documented in the CLDP that the individual has a sister in another state who was provided with community living information by the Contract LA by mail and telephone conversation. There was no further reference to the sister's involvement or notification in the ensuing documentation of community exploration and provider interviews.<br>• For Individual #512, the preferences for community living indicated the IDT preferred a home in a specific geographic location as it hope this might increase family contact. There was no further mention of family involvement or notification as to activities that had been undertaken, including tours or scheduling of pre-placement visit<br><br>Only four of six (67%) in process CLDPs had any information regarding community resource education, including the history of the individual's or the LAR/family exposure to alternative community placements.<br><br><u>Conclusion:</u> This provision was found to be not in compliance. | |
| T1d | Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving. | <u>Adequacy of Assessment:</u><br>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.<br><br>The Monitoring Team interprets this requirement of comprehensiveness to include that the assessment must accurately reflect needs for supports and services, not simply that assessment documents be produced within 45 days of departure. The Facility was taking some action to improve the quality of ISP assessments by requiring that departmental and discipline heads review completed assessments, but this was not yet being consistently implemented as described in Provision F1c. The Monitoring Team strongly recommends the Facility take all necessary actions, through policy directive, training and | Noncompliance |

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| | | quality monitoring, to assure assessments are being completed in a thorough, accurate and detailed manner.<br><br>Timeliness of Assessment:<br>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 continue to focus its attention on whether these assessments were adequately prepared as described immediately above.<br><br>Conclusion: 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. Given the number, and in at least one case severity, of the adverse outcomes, the Monitoring Team recommends an additional layer of review and scrutiny be given to CLDPs before approval and to the subsequent PMM over the course of the next six months. | |
| T1e | Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility. | LA Continuity of Care Process:<br>The Monitoring Team reviewed seven LA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan and found that these appeared to have been completed in accordance with policy expectations.<br><br>Pre-Move Site Visit Completed by Facility:<br>DSSLC had also been completing Pre-Move Site Reviews, as required by policy. The ATC and 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. Reviews for Pre-Move Review Site Reviews for individuals who had moved to a community home since the last monitoring visit indicated the documents reviewed appeared to have been completed in a timely manner following the CLDP and prior to the actual transition date, per the completion date. The instrument also called for the attestation that verified the provider is in good standing with DADS, using the DADS Quality Reporting System website, and to attach the printed verification. These were included for seven of seven individuals (100%).<br><br>The Facility often verified that the stated essential supports were present but this was not sufficiently consistent. In three of seven (43%) Pre-Move Site Reviews, there were supports that were not fully documented. The Facility also did not document a due date for implementation of non-essential (post-move) supports that were not yet in place. The Facility did not obtain a concrete plan for supports that were to be implemented between the 7-Day and 45-Day visits as described in Provision T2a below. As a result, it was often not possible to verify some non-essential (post-move) supports were being | Noncompliance |

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| | | implemented until well after their due date. The rationale for obtaining a plan from the provider rather than just indicating that a support is not yet due is to avoid such gaps. The Facility should ensure it obtains detailed information from the provider as to the plan for implementation.<br><br>The Facility's ability to diligently ensure the presence of supports continued to be hampered by the failure of the IDT to provide an adequate assessment of each individual's support needs and to use assessment findings to develop an adequate support plan. For example, as discussed above in Provision T1c1, Individual #505, the IDT failed to capture this information from the assessment process and identify a support that could have facilitated the individual's integration and adjustment in her new environment.<br><br><u>Conclusion:</u> This provision was found to be not in compliance. This provision also relies on supports and evidence having been adequately identified in the CLDP comprehensive assessments and the Monitoring team did not find this to be the case, as described under Provisions T1c1 and T1d, further 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. | <u>Quality Assurance Processes to Ensure Development of CLDPs:</u><br>QA procedures related to ensuring the development of CLDPs remained essentially unchanged since the last monitoring visit. They focused primarily on the tracking of the provision of the 45-Day assessments from the various disciplines by CFR staff using the Assessment Checklist. There had been no significant focus on ensuring the quality of the assessments used in developing the CLDP. Given the concerns related to the adequacy of the CLDP and some negative outcomes, as detailed in Provision T1c1 and T1d, the Monitoring Team strongly encouraged the Facility to undertake an initiative to improve the quality of all of the processes involved in the CLDP, in concert with its "Assessment of Assessments" project already underway.<br><br><u>Quality Assurance Processes to Ensure Implementation of CLDPs:</u><br>The Pre-Move Site Review conducted by the ATC or Placement Coordinator continued to provide 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 practice, as the existing LA pre-move site visit did not focus heavily on ensuring specific supports were in place; however, the process needed to be improved to be fully functional as a mechanism for ensuring quality.<br><br><u>Conclusion:</u> 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 | Noncompliance |

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| | | 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 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. | <u>Obstacle Information Gathered:</u><br>The Facility gathered data on the identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. The staff in the Department of CFR were responsible for reporting this data to DADS, but were unclear on whether this report was to be made on an annual or a quarterly basis.<br><br><u>Annual Obstacle Analysis by Facility:</u><br>A new Obstacles Report had not been issued since FY 2011, with data as of 8/31/2011. The Monitoring Team has reported on this analysis in both of the last two reports and had no new findings in this area.<br><br><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. The Monitoring Team looks forward to reviewing the upcoming Annual Report in order to assess progress in this area. | Noncompliance |
| T1h | Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be | <u>Timeliness of Issuance of the Community Placement Report:</u><br>The Facility issued an updated Community Placement Report on Monday, October 08, 2012, covering the period of 4/1/2012-10/08/2012. The report was issued in a timely manner.<br><br><u>Required Reporting Categories:</u><br>The report was in the standardized format as prescribed by DADS State Office. It listed:<br>• Nine community placements<br>• Sixteen current referrals | Noncompliance |

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| | appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I. | • No rescinded referrals<br>• Two individuals who preferred community, not referred-LAR choice<br>• Six individuals who preferred community, not referred-other reason<br>• No individuals for whom the LAR prefers community, not referred.<br><br><u>Reporting on Individuals not referred due to LAR choice:</u><br>The data provided in the category of individuals who preferred community, not referred-LAR choice did not appear to be 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, the Facility provided an additional document, the Obstacles Database, which indicated many individuals were not referred due to LAR Choice.<br><br><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.<br>. | |
| **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 | <u>Policies and Procedures related to Post-Move Monitoring:</u><br>The Facility reported there had been no changes or additions to policies related to Post-Move Monitoring. The Facility had developed a 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 laid out procedures to ensure there would be close communication between SSLCs to facilitate IDT review and recommendations. This was in response to a recommendation made during the previous site visit.<br><br><u>Staffing:</u><br>The current level of a single position appeared to be adequate to the PMM workload. The Placement Coordinator provided back-up when the Post-Move Monitor was unavailable. | Noncompliance |

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| | 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. | The Monitoring Team reviewed PMM Checklists for seven 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:<br><br>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 were made within the required timeframes.<br><br>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.<br><br>Assessment of Presence of Supports Called for in CLDP: The PMM Checklists reviewed during this compliance visit did not consistently provide in-depth information that painted a picture of the individual's adjustment as had been observed in previous monitoring visits. The Post-Move Monitor stated she had had not continued to maintain a comprehensive record of emails and phone logs that documented careful follow-up and loop closure in all cases. This was particularly concerning in the case of the individual who died following community transition. The CLDP called for a doctor to doctor consultation to be completed between the Facility physician and the selected community Primary Care Provider (PCP) within the first seven days. Given the individual's complex medical needs as described above in Provisions L1 and T1c1, this should have been a high priority. The documentation available provided no confirmation an actual conversation had taken place between the physicians. It was belatedly discovered the Facility physician made a call well after the required seven day period to the PCP office, spoke with the receptionist and faxed materials for the PCP to review. The PCP, having received the materials just shortly before the individual's first visit, was reported to have declined to complete a full examination at that time without time to review and required the visit to be re-scheduled. The Monitoring Team requested confirmation that the PCP visit had been completed. The Facility had no such documentation and was not able to produce any documentation over the course of the week of the site visit to verify the visit had ever taken place. It was also not clearly evident that the Facility doctor ever spoke directly to the PCP. This individual had a complex medical status that demanded close scrutiny, particularly in the crucial transition period and the Facility failed to ensure these supports had been provided.<br><br>Facility's Efforts to Ensure Supports are Implemented: The Monitoring Team was disappointed to find the Facility's practice of excellent documentation of efforts to ensure | |

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| | | supports were implemented had not been consistently continued. The Post Move Monitor indicated she was not consistently maintaining a comprehensive file with materials she collected to verify the implementation of supports as well as to document follow-up. This made it difficult to confirm the accomplishment and/or timeliness of the Facility's efforts to ensure that supports were implemented. The Monitoring Team was particularly concerned that this failure to maintain adequate documentation was most evident in the case of the individual who died shortly after the initial 90 day PMM period. One of the most significant failures in documentation concerned the examination of the individual by the community PCP as described above. The Monitoring Team recommends the Post-Move Monitor resume her previous exemplary documentation practices.<br><br><u>Barriers to thorough PMM Review and Improvements Needed in Monitoring:</u><br>• DSSLC kept good documentation of IDT review of the PMM Checklists, but it was noted that there was often a lapse of several weeks and sometimes more than thirty days between the PMM visits and the review by the team. This could limit the potential effectiveness of any IDT interventions that might be necessary. The Monitoring Team recommends the Facility adhere to a timelier requirement in all cases.<br>• 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.<br><br><u>Conclusion:</u> This provision was found to be not in compliance. The PMM process was sometimes implemented in a diligent manner, but some gaps and deficits were identified during this compliance visit that may have contributed to adverse outcomes for individuals. | |
| 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 | <u>Observation of Post-Move Monitoring Visit:</u><br>The Monitoring Team accompanied the Post-Move Monitor on a 45-Day PMM visit for Individual #493. A review of the previously completed PMM Checklists indicated visits had been made to all required environments in the 7-Day visit. Both were limited to the home because a glitch in verification of an individual's community Medicaid eligibility had resulted in the individual not being able to enroll in the selected day program.<br><br>The Post-Move Monitor continued to demonstrate concern and a degree of diligence in | Noncompliance |

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| | the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date. | this on-site review. 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 and with the foster care provider. The Post-Move Monitor very appropriately focused attention on the most emergent needs of the individual, including an ongoing sleep disturbance and weight loss. She evaluated the presence of 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.<br><br>However, not all supports were personally observed. For example, the individual had a number of pieces of adaptive equipment for dining and there was not an observation that each of these was present. Likewise, there were many environmental control devices prescribed in the CLDP, but these were not all observed for and/or inquired about. The individual was also supposed to have lotion applied to her skin daily; the Post-Move Monitor did ask the provider if this was continuing, but did not observe for the presence of the lotion. There was no discussion of alternatives for day programming.<br><br><u>Conclusion:</u> This provision was found to be not in compliance. The Monitoring Team found deficiencies in the monitoring process during this particular PMM visit and there was concern noted about the diligence of the PMM process in the case of Individual #505 as described in Provision T2a above. | |
| **T3** | **Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations. | | |
| **T4** | **Alternate Discharges -** | | |
| | Notwithstanding the foregoing | <u>Number and Categories of Alternate Discharges:</u> | Substantial |

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| | provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals:<br>(a) individuals who move out of state;<br>(b) individuals discharged at the expiration of an emergency admission;<br>(c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe;<br>(d) individuals receiving respite services at the Facility for a maximum period of 60 days;<br>(e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission;<br>(f) individuals discharged pursuant to a court order vacating the commitment order. | DSSLC reported one alternate discharge during the past six months. The individual transferred to another SSLC.<br><br><u>Compliance with CMS-required Discharge Planning Procedures:</u><br>The Monitoring Team reviewed the discharge packets for Individual #573 for consistency with CMS-required discharge planning procedures as well as with protocols established in DADS SSLC Draft Policy 019: Most Integrated Setting Practices, undated. The latter policy described a procedure and provided a format for a Discharge Reassignment Summary. The discharge appeared to be prepared in a manner consistent with all requirements.<br><br><u>Conclusion:</u> This provision was found to be in substantial compliance. | Compliance |

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

1. The Monitoring Team recommends that the Facility's action steps be further operationalized with clear criteria to determine if the actions are producing the desired results. (Self-Assessment)
2. The Facility should use post-move adverse outcome data to continually evaluate and improve its CLDP and PMM processes. (Provision T1a)
3. The Facility should develop a process to collecting data regarding the implementation of ISP Action Plans for community awareness and education in order to ensure these receive sufficient priority by IDTs. (Provision T1b2)
4. The Facility should examine how it might expand on the CLOIP tour process to make more such opportunities available to individuals. (Provision T1b2)
5. The Facility should also consider how it can address each of the criteria in this provision to create a comprehensive coordinated plan for

community living education and awareness. (Provision T1b2)

6. Ensure timeliness of actions related to referrals and community placements are included in its development of the quality assurance procedures required under Provision T1f. Quality assurance processes should be undertaken focusing on whether an adequate and reasonably intensive exploration and development process is taking place, including the collection of data regarding the number and types of community exploration activities undertaken for each individual on the list of current referrals. (Provisions T1b1, T1d, and T1f)
7. The Department of CFR should develop and monitor a tracking list of action steps that need to be implemented once a referral is made and make follow-up with IDTs to ensure timely actions when necessary. (Provision T1c)
8. Given the number, and in at least one case severity, of the adverse outcomes, the Monitoring Team recommends an additional layer of review and scrutiny be given to CLDPs before approval and to the subsequent PMM over the course of the next six months. (T1c1, T1d, T2a)
9. The Facility should ensure it obtains detailed information from the provider during the Pre-Move Site Review as to the plan for implementation for all non-essential supports. (Provision T1e)
10. The Facility should undertake an initiative to improve the quality of all of the processes involved in the CLDP, but in particular, an initiative to improve the quality of all of the processes involved in the CLDP, in concert with its "Assessment of Assessments" project already underway. (Provision T1f)
11. DADS and the Facility should examine the accuracy of data in the Community Placement Report, particularly related to the number of individuals who prefer community living but are not referred due to LAR choice. (Provision T1h)
12. The Monitoring Team recommends the Facility adhere to a timelier requirement in all cases of IDT review of the PMM checklists. (Provision T2a)
13. 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. (Provision T2a)
14. The Monitoring Team recommends the Post-Move Monitor resume her previous exemplary documentation practices for all PMM reviews and follow-up. (Provision T2a)

| SECTION U: Consent | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. Denton State Supported Living Center (DSSLC) Self-Assessment, 09/24/12<br>2. Denton State Supported Living Center Action Plans, 09/24/12<br>3. Denton State Supported Living Center Report for Monitors, dated October 8, 2012<br>4. Section U Presentation Book materials<br>5. Section U – HRO Activity Information<br>6. DADS Policy 019: Guardianship, effective 3/7/2012<br>7. DADS Policy 057: Self-Advocacy, effective 05/30/12<br>8. DSSLC Policy CMGT 30: Guardianship, dated January 16, 2012<br>9. DSSLC Policy CMGT 27: Affirming and Protecting Rights, effective 01/20/2012<br>10. DSSLC Policy CMGT 04: Legal Consent, dated June 1, 2006<br>11. DSSLC Policy CMGT 27J: Right to Autonomy, dated February 24, 2011<br>12. DSSLC Policy CMGMT 40: Advocate, effective 05/15/2012<br>13. DSSLC Policy CMGMT 41: Self-Advocacy, effective 05/30/2012<br>14. Rights Assessment, Form 6614, dated September 2011<br>15. Completed Rights Assessments for Individuals #91, #111, #116, #475, #626, #682, and #703<br>16. ISP Monitoring Tool<br>17. Guardianship Committee Minutes for the past six months<br>18. Self-Advocacy Minutes for the past six months<br>19. 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.<br>20. Document entitled "One on One QDDP & IDT Training Through ISP Meetings," dated September 2012<br>21. Document entitled "Annual ISO meetings Attended for New Rights Assessment"<br>22. Since the last review, a list of individuals for whom an LAR or advocate has been obtained<br>23. Over the six (6) months preceding the monitoring visit, documentation that reflects the activities of the facility to obtain LARs or advocates<br>24. Guardian Specialists Monthly Updates on Individuals on Priority List & Preliminary Priority List, dated August 2012<br>**People Interviewed:**<br>1. Pam Garrett and Sezer Ruzek, Human Rights Officers (HROs)<br>2. Lori Powell, Director of Quality Assurance<br>**Meeting Attended/Observations:**<br>1. ISP for Individual #250<br>2. Guardianship Committee<br>3. Human Rights Committee |
| | **Facility Self-Assessment:**<br>The Facility submitted a Self-Assessment for Section U. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. |

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| | The Facility did use certain relevant data sources and presented some findings based on specific, measurable indicators, such as tracking the completion percentage of QDDP and IDT training. However, overall, the Facility did not consistently measure the quality of items, but rather merely their presence. The Facility was requiring QDDPs to demonstrate competency in the completion of the Rights Assessment, but the indicators of how that competency was measured were broad and not specific enough to determine whether a team was really making an adequate assessment of decisional capacity. If there were such indicators, they would constitute one appropriate means for assessing progress in a quantitative manner. For example, one of the criteria upon which competency was measured was whether the determinations were fully justified, but there was no description found in the training handouts or elsewhere of what would constitute a full justification. The Facility should develop indicators that are sufficiently clear and specific that they could provide a consistent and reliable measure of the desired outcome.<br><br>For Section U, in conducting its self-assessment, the Facility had not used monitoring/auditing tools up to this point. The Self-Assessment did note there was a newly created and implemented monitoring tool, the ISP Monitoring Tool, which had begun to be used to evaluate how the teams were using the rights assessment and to measure the outcomes. The ISP monitoring tool represented an overall improvement in the Facility's processes for ISP review, but still had certain deficiencies in terms of measuring outcomes, including:<br>• Did not always include adequate indicators and/or methodologies to allow the Facility to determine compliance with the Settlement Agreement.<br>• Did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. There was no process described to ensure the staff responsible for conducting the audits/monitoring, QA staff and the QDDP Coordinator, had been deemed competent in the use of the tools.<br><br>The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance.<br>• Actions were largely reported as having been completed, and the Facility data did not identify any further areas of need/improvement. There were no actions described to be taken to ensure a standardized and valid tool for assessment of decisional capacity even though this had been raised as a fundamental concern in each prior monitoring visits. The Action Plans indicated a tool had been developed to assess the outcomes of the pilot Rights Assessment project as recommended by the Monitoring Team during the last site visit and indicated the QA Director had been responsible its completion. It appeared the Self-Assessment was referring to the ISP auditing tool, but that instrument did not address the objectivity, standardization or validity of the Rights Assessment process.<br>• The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. The Facility's process for determining compliance focused largely on inputs; that is, on activities it undertook rather than on the outcomes those activities produced. There needs to be assessment both of policies and procedures and on outcomes. |

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| | Overall, the Facility rated itself as being in compliance with the following provisions of Section U: Provision U1 and U2. This was not consistent with the Monitoring Team's findings, which did not find compliance in either of the provisions. |
| | **Summary of Monitor's Assessment:**<br>This Section was not yet in compliance. A summary of noted progress included: 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. This strategy held promise for contributing objectivity to the prioritization process and should be reviewed by DADS for its potential statewide applicability. The Facility was to be commended for its continuing 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. The Facility continued training and using the expanded Rights Assessment, The Facility continued to provide support for self-advocacy and had begun using some formal choice-making materials as a part of its self-advocacy activities. The Facility also continued to develop its capacity to provide advocates for individuals as an alternative to guardianship. The HROs continued to be very actively engaged in a number of other activities related to obtaining guardians and advocates.<br>Specific findings for each provision are as follows:<br><br>**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. 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 as noted above.<br><br>The Facility continued training and using the expanded Rights Assessment, but an evaluation of the instrument's application as a standardized tool for assessing decisional capacity remained to be accomplished. 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. This remained the most significant barrier to achievement of substantial compliance for this Section. The IDTs continued to rely almost solely on their own subjective assessment of capacity, with no objective standardized criteria. As part of undertaking an effective and appropriate large-scale effort to solicit guardians, DSSLC must 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. |

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| | **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. This remained the biggest barrier toward achieving compliance with this provision The Facility continued to undertake 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. The Guardianship Committee continued to meet regularly. The HROs continued attended ISP meetings to provide technical assistance and consultation to teams on guardianship and rights assessment issues and had focused much effort on staff training. A new DADS policy on Self-Advocacy had recently been issued, and DSSLC did continue to provide support for self-advocacy, including incorporation of the use of some formal choice-making curriculum as had been recommended in the past. The Facility had also recently begun its advocacy program. |

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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><br>DADS State Office had issued a new policy DADS Policy 019: Guardianship, effective 3/7/2012, with five Exhibits. The Monitoring Team commented on the content of this policy during the previous review. The stated purpose of this 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 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 individual decision-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<br><br>Policy 019 addressed 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.<br><br>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 | Noncompliance |

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| | | 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. 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. DADS should clarify its intent in regard as well.<br><br>The Monitoring Team remained concerned, as suggested previously, 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. 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, but there was no known projected date for formal issuance of an approved Rights Assessment methodology 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.<br><br>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.<br><br>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 | |

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| | | 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 developed and were providing ongoing training to IDTs in the process, as further described below.<br><br><u>Maintenance of Prioritized List:</u><br>The Facility maintained a prioritized list. It continued to use prioritization criteria that were tied to its Integrated Risk Rating (IRR) data. During the previous review, the Monitoring Team had recommended that the Facility confirm with DADS that this methodology was acceptable. They had done this on 8/30/12 and received a letter indicating DADS approval to continue to pilot this process. They had also submitted their prioritization process for review to the local Probate Court and had received a letter indicating the Court's positive assessment.<br><br>The IRR 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. The Priority List was populated with the IRR data on an ongoing basis as these assessments were completed. As a result, the list was 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 attempting to obtain objective and individualized information on which to base decisions regarding priority needs for decision-making assistance. 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. This strategy held promise for contributing objectivity to the prioritization process and should be reviewed by DADS for its potential statewide applicability<br><br>This list was 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 Monday, September 17, 2012. There were ten names on the list, all of whom had been determined to have the most significant need for assistance in decision-making according the prioritization process described above. The remaining 154 individuals without a current guardian were included in the "Preliminary Priority List" and were ranked on a priority scale from one (least in need) to twelve (most in need). The Monitoring Team had recommended during the previous site visit that the HROs also use this list 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 and to consider how this status might | |

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| | | factor into the prioritization. The Facility had added this functionality to the process and there were six names on this section of the list.<br><br><u>Assessment of Functional Capacity to Render a Decision:</u><br>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 continued to pilot an expanded Rights Assessment, as provided for under DSSLC Policy CMGT 27: Affirming and Protecting Rights, effective 01/20/2012. The HROs continued to provide training on the use of this new tool to QDDPs and IDTs in the pilot area. The Monitoring Team reviewed two documents, entitled "Annual ISO meetings Attended for New Rights Assessment" and "One on One QDDP & IDT Training Through ISP Meetings" which indicated that 31 QDDPs and IDTs had received training in the Rights Assessment process since the pilot began in March 2012. In addition, the HROs were reviewing a sample Rights Assessments completed by each IDT and providing feedback to the QDDP for corrective action. This had been completed for 27 QDDPs. The Monitoring Team commends the initiative and hard work of the HROs in this effort.<br><br>A total of 208 Rights Assessments had been completed using the new process. The Monitoring Team reviewed a sample of seven Rights Assessments, including one from each home, and observed the process during one ISP in order to assess the outcomes of the training as well as the appropriateness of the overall assessment strategy. There was evidence that the Rights Assessments continued to reflect a more thoughtful approach to assessing an individual's discrete needs and abilities in the area of decision-making. There were instances in which the IDT made an affirmative decision that an individual could give informed consent in certain areas. For example, IDTs determined that several individuals were able to provide consent in the area of programming. In addition, for Individual #111, the IDT made a determination the individual could give informed consent in the financial area and, in a later section of the Rights Assessment, there was no restriction in managing money. This internal consistency was not always apparent, however; for Individual #682, the IDT also found the individual could give financial consent, but there was then a restriction in money management found later in the document.<br><br>The Rights Assessment also directed the IDT to indicate whether the individual could provide informed consent in each of the areas and, if not, to discuss how and what level the individual could participate in decision-making. The Monitoring Team commends this approach and recommends continued training for the IDTs in its implementation. In many instances, the IDTs did provide a discussion of how an individual might communicate some form of input, but there was usually no specific expectation set for how staff would be expected to use that information to support participation in decision- | |

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| | | making. It is recommended this be included in the process and integrated throughout the ISP in appropriate places.<br><br>While it may prove to be useful, the draft Rights Assessment in use in the pilot was not a currently accepted standardized tool for assessing decisional capacity. This remained the most significant barrier to achievement of substantial compliance for this Section. The IDTs continued to rely almost solely on their own subjective assessment of capacity, with no objective standardized criteria. The Monitoring Team recognized the value of the professional opinions of the IDT, but the Monitoring Team had encouraged 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.<br><br>The HRC review of the informed consent assessments also continued to be somewhat more rigorous as observed during the previous visit. The Monitoring Team attended a portion of the HRC meeting held during the week of the compliance visit and observed the review of two Rights Assessments. While it remained more clearly individualized than in the past, the Monitoring Team did not observe that the process required significant evidence of ISP strategies to enhance decision-making capacity relevant to individuals' identified needs in the informed consent areas. The HRC review should provide feedback and guidance to IDTs toward providing more training and support for individuals' decision-making capacities.<br><br><u>The Facility had recently begun using a new ISP Monitoring Tool.</u> Ten questions related to decision-making capacity and informed consent were included in the tool. No data from the tools was referenced as it was a very new process. The ISP monitoring tool represented an overall improvement in the Facility's processes for ISP review, but still had certain deficiencies in terms of measuring outcomes for this Section. The tool:<br>• Did not always include adequate indicators and/or methodologies to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. For example, compliance in Section U is dependent in part on the use of a standardized and objective tool to assess decisional capacity. The ISP monitoring tool did not provide an indicator that assessed whether the tool used to assess capacity was standardized or objective.<br>• Did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. The questions posed for Section U tended to be very broad and did not lay out any specific expectation for what would constitute a positive answer. Many of the questions asked whether the IDT discussed an issue, but there were no criteria for what an adequate | |

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| | | discussion should entail.<br>• There was no process described to ensure the staff responsible for conducting the audits/monitoring, QA staff and the QDDP Coordinator, had been deemed competent in the use of the tools. The Facility acknowledged that adequate inter-rater reliability had not yet been established between the Facility staff responsible for the completion of the tools.<br><br><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 continued training and using the expanded Rights Assessment, but 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><br>DADS Policy 019: Guardianship, effective 3/7/2012, 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:<br>• Establishing a Guardianship Committee that meets regularly to discuss guardianship needs at the State Center;<br>• Working with the QDDP Coordinator and QDDPs to develop and maintain a prioritized guardianship list of individuals in need of a guardian;<br>• Providing information to the State Center's Parent/Family Association members regarding alternatives to guardianship and local guardianship programs and resources;<br>• Sharing appropriate information regarding individuals in need of a guardian with local guardianship programs as permitted by law;<br>• Soliciting information from local guardianship programs regarding community supports available to assist with guardianship fees, court costs, and other expenses; and,<br>• 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.<br><br>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 and | Noncompliance |

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| | | requirements found in the policy include meeting regularly to discuss guardianship needs at the center and maintaining 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. In addition, the Facility was to make monthly progress notes regarding the status of individuals referred to the Guardianship Committee.<br><br>DADS had also issued Policy 057: Self-Advocacy, effective 05/30/12. The stated purpose of the policy was to ensure that individuals living in State Centers are provided the opportunity to participate in self-advocacy opportunities, including education surrounding self-advocacy and participation in self-advocacy meetings and events. The policy designated the HRO to serve as the Self-Advocacy Coordinator for the Facility. The policy focused almost exclusively on providing a variety of supports to formal self-advocacy groups. The only exception was the responsibility to conduct an annual self-advocacy in-service for individuals, families and LARs and State Center staff. The supports for self-advocacy formalized in this policy are commendable, but the Monitoring Team also encourages DADS and the Facility to consider a broader vision of how self-advocacy may be incorporated into the everyday lives of individuals. The Facility had also issued a local DSSLC Policy CMGMT 41: Self-Advocacy, effective 05/30/2012 that was consistent with the statewide policy.<br><br>The Facility had also promulgated DSSLC Policy CMGMT 40: Advocate, effective 05/15/2012. It stated the purpose of the policy was to ensure that individuals receiving services from State Supported Living Centers were provided access to a personal advocate, by defining the program designed to recruit volunteer personal advocates for those individuals who do not have active family members who serve as personal advocates or individuals who request a personal advocate in addition to their active family member. An Advocate was defined as a person who advocates solely for the fulfillment of the needs of an individual, to help them grow and develop, to assure adequate assessment of the individual's strengths and needs, to assist in planning and monitoring the implementation of habilitation plans and the Personal Support Plan, to represent the individual's interest, and to protect his/her rights and civil liberties.<br><br>The policy called for the HRO to serve as the facility Advocacy Coordinator. Specific duties of the Advocacy Coordinator included the following:<br>• Working with the QDDP Coordinator and QDDPs to develop and maintain a prioritized list of individuals in need of an advocate; | |

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| | | • Recruitment of persons to serve in the role of an advocate;<br>• Ensuring that all advocate candidates complete the necessary screenings to become a registered volunteer at the State Center;<br>• Ensuring that all advocates participate in initial and annual training related to individual's rights, Texas Department of Aging and Disability Services' Rights Process and the prevention and reporting of abuse and/or neglect;<br>• Successfully pairing individuals with potential advocates.<br><br>The Facility Guardianship Committee was to be expected to review IDT requests for need of Advocate during monthly Guardianship Committee meeting and document this information in Guardianship Committee Meeting Minutes and monthly progress notes.The facility Human Rights Officer would be responsible for maintaining data to be entered into a state-wide database.<br><br><u>Facility Efforts to Obtain LARs:</u><br>The Facility reported nine LARs had been obtained for individuals living at DSSLC during past six months. Of these, six individuals were newly adjudicated incompetent and three obtained successor guardians. The Facility had completed an expanded Rights Assessment under the new pilot process for each of the individuals, as recommended by the Monitoring Team during the previous visit, such that the Committee would have the most useful information possible upon which to determine appropriate actions. Several other referrals and applications were in process.<br><br>Other organized efforts toward appropriately obtaining LARs as well as other appropriate decision-making supports for individuals included:<br>• <u>Guardianship Committee</u>: 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. Additional training and informational presentations were provided to the Committee on an ongoing basis at most meetings. For example, Legal Aid of North West Texas attended one meeting to give information about accepting two cases from the Facility free of charge for the individuals who needed a guardian. The Monitoring Team was able to attend the Committee meeting held during this compliance visit. There was good attendance and participation. The meeting again appeared to be largely informational as the HROs reported on their activities for individuals on the Preliminary Priority List and referrals for guardians or advocates received from IDTs. 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 HROs continued to complete a comprehensive monthly status summary of individuals referred to the Guardianship Committee for either a guardian or advocate and provided a review of this report in the meeting.<br>• Advocacy Program: The Facility had initiated an Advocacy Program since the previous monitoring visit, consistent with the policy described above. QDDP staff had been trained in the process. The Facility also held an initial meeting to which all staff were invited to review the new Advocacy policy and to learn the requirements for becoming an advocate. The HROs noted that the program was targeting existing staff for the time being to take advantage of their having already been through a background check. At the time of the monitoring visit, one staff person had been officially designated as an advocate and two more were in process. The Facility program ensured that staff who work with an individual in any capacity could not also serve as advocate in order to avoid any potential conflict of interest.<br>• 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. There had been considerable emphasis placed on informed choice and consent over this time period. The impact this may have had on the capacity of individuals to make informed choices was not measured, however. The Facility should consider how it might assess the value, in terms of outcomes, of the training it is providing.<br>• Other Activities of the Guardianship Coordinators: The HROs continued to be very actively engaged in a number of other activities related to obtaining guardians and advocates. In addition to those described throughout this section, these included:<br>o In August 2012, the HRO's attended ICF/IDD (Intermediate Care Facilities for Individuals with Developmental Disabilities) Conference and Training on Guardianship and Surrogate Decision Making in Austin.<br>o In September 2012, the HROs attended a State Wide Human Rights Officer's Training including training on Guardianship and Advocate policies.<br>o The HROs attended guardianship training as a part of the Consumer Rights Conference in Austin in October 2012.<br>o The HROs arranged for representatives of Legal Aid of North West Texas to attend the Provider Fair to meet with potential guardians and to evaluate if they meet the criteria to receive financial aid.<br><br>Conclusion: This Provision was found to be not yet in compliance. The Facility was to be | |

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| | | commended for its continuing 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 must 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. | |

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

1. DADS should provide an appropriate methodology to determine the actual need for guardianship that includes standardized and objective criteria through the formal promulgation of policy as soon as possible. (Section U)
2. The actual responsibilities of the Guardianship Committee under DADS Policy 019: Guardianship, effective 3/7/2012, should be clarified. (Provisions U1 and U2)
3. DADS should clarify how the two sets of criteria for prioritization found in DADS Policy 019: Guardianship, effective 3/7/2012, are meant to be integrated. (Provision U1)
4. DADS should review the prioritization criteria tied to the Integrated Risk Rating (IRR) data in use at the Facility for its potential statewide applicability. (Provision U1)
5. IDTs should provide in the Rights Assessment specific expectations for how staff will be expected to support individual's participation in decision-making, consistent with the assessment of the input they can provide. . (Provision U1)
6. The Facility should consider how it might assess the value, in terms of outcomes, of the impact self-advocacy training on consent and choice making may be having on the capacity of individuals to make informed choices. (Provision U2)

| SECTION V: Recordkeeping and General Plan Implementation | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment 9/24/12<br>2. DSSLC Action Plans 9/24/12<br>3. DSSLC Report for Monitors 10/8/12<br>4. Presentation Book for Section V<br>5. DADS Policy 020.1 Recordkeeping Practices 3/05/10<br>6. DADS Policy 001.1 Use of Restraint 4/10/12<br>7. DSSLC Policy CM-25 Recordkeeping Practices 2/2/12<br>8. DSSLC Policy CMGMT-20 Use of Restraint 6/1/12<br>9. DSSLC Policy CMGMT-40 "Advocate" 5/15/12<br>10. Cover email notifying staff of new Policy CMGMT-40<br>11. DSSLC Policy CMGMT-41 Self-Advocacy 5/30/12<br>12. Cover email notifying staff of new Policy CMGMT-41<br>13. DSSLC Policy CMGMT-15 Quality Assurance 9/1/12<br>14. DSSLC Policy CMGMT-17 Home Shift Log Policy 6/15/12<br>15. DSSLC Policy CMGMT-32 Physical Nutritional Management (PNM) 10/5/12<br>16. DSSLC Policy DS-12 Dental Services Dental Annual Examination and Summary 9/11/12<br>17. DSSLC Policy DS-25 Dental Services Quality Assurance 9/11/12<br>18. DSSLC Policy Committees & Councils-05 Pharmacy and Therapeutics Committee 7/5/12<br>19. List of new or updated Facility policies since last compliance visit<br>20. Response to document request for a copy of communication to staff to inform them of policy<br>21. DSSLC Policies and Procedures Manual Index 9/5/12<br>22. Share Drive assessment folder for Individual #578<br>23. Active Record, Individual Notebook, and Master Record for Individuals #172 and #273, and vocational area notebook for Individual #273<br>24. Master Record Purging Schedule revised 8/9/12<br>25. Active Record audit forms and emails and other documentation regarding corrective actions for the 20 audits conducted June through September 2012 for June: Individuals #364, #383, #626, #633, and #660, July: Individuals #80, #163, #563, #602, and #608, August: Individuals #209, #539, #628, #633 (a repeat selection from June), and #768, and September: #13, #84, #123, #355, and #632<br>26. Audit sample lists of individuals selected randomly by data analyst for May, June, July, August, September, and October 2012<br>27. Records audit tools, which included definitions<br>a. Settlement Agreement Cross-Referenced with ICF-MR Standards, Section V<br>b. Active Record Order & Guidelines (AROG) revised 9/26/12<br>c. Individual Notebook and Guidelines revised 3/17/11<br>d. Interview Tool for use of the Record Guidelines and instructions for implementing the interview |

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| | 28. Corrective actions taken in Active Record and Individual Notebook for Individual #633<br>29. Response to document request regarding procedures for tracking findings of audits<br>30. Response to document request regarding procedures for corrective actions on records audited<br>31. Sample Document Tracking forms for several individuals, dated 9/16/12-9/22/12<br>32. ISP Monitoring Tool form<br>33. New Employee Organization training materials including a handout of training slides, a handout called Observing and Reporting in MH and ID Facilities, and a Documentation Quiz for the training for two staff<br>34. Trend data for Section V monitoring, and quarterly Section V data report to QA/QI Council (undated, with data through July 2012)<br>35. Graphs of timeliness of assessments by Unit, by discipline, by discipline within each unit, and by apartment, April-September 2012<br>36. CAP Tracking entry of 9/4/2012 on the issue of timeliness of Assessments submitted to the Shared Folder, and multiple emails from Lori Powell notifying department and unit directors of delinquent assessments<br>37. Memo of 8/31/12 from Lori Johnson to Clinic Clerks/Records Clerks Re: Scanning (of consults, test results, W-rays, and hospital records)<br>**People Interviewed:**<br>1. Group interview of Melissia Steele, Unified Records Coordinator (URC), Betsy Knight, Client Records Administrator, and Lori Powell, Quality Assurance Director<br>2. Group interview of Leslie Clark, QDDP Coordinator, and Kizzy Mickels, Lead QDDP for Timberhill<br>3. Group interview of Steven Kubala, M.D., Medical Director, and Randy Spence, M.S., BCBA, Director of Behavioral Services<br>4. Lori Powell, Quality Assurance Director<br>5. Ken Horstman, Director of Residential Services<br>6. Arifa Salam, M.D., Lead Psychiatrist<br>**Meeting Attended/Observations:**<br>1. ISP annual planning meeting for Individual #250<br>2. Homes 502D, 511A, and 526D |
| | **Facility Self-Assessment:**<br>The Facility provided a self-assessment and action plans. For the self-assessment, the Facility reported for each provision the activities engaged in to conduct the self-assessment, results of the self-assessment, and a self-rating with rationale for the rating.<br><br>For some items reviewed by the Facility, data were provided; for others, information stated the status of a process or described the process. In some cases, the data provided were items found in the Facility quality assurance (QA) reporting; this integration allows self-assessment to be a routine and ongoing activity that can be used to identify areas for correction or improvement.<br><br>An example of using data was the report that 85.56% of Individual Notebooks were put away and secure. An example in which QA reporting could have been used but was reporting that monitoring tools indicated |

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| | that records need improvement with legibility (and listed other issues); the Facility records audit process gathers and reports this information, which could have been reported for the self-assessment.<br><br>The Facility reported that none of the provisions of this Section were yet in compliance. The Monitoring Team concurs.<br><br>The Action Plans included a number of actions taken since the prior compliance visit. Many of those were reported as "complete" or "complete and ongoing"; the Monitoring Team verified several of these through observation, review of documentation, or interview. Other action steps addressed issues raised either in prior compliance reports or in the self-assessment and record audits. For the most part, these appeared to address significant issues that must be corrected. One issue not addressed (and that relates to use of audit and self-assessment information across each provision of this section) is to establish—once the other steps toward implementation of actions have been completed—a process to identify areas for improvement or correction based on the information and data provided as a result of these action plans, to determine whether they are effective and whether documentation and use of records for decision-making could continue to be improved. |
| | **Summary of Monitor's Assessment:**<br>The Facility had continued to make progress toward compliance, in terms of maintaining a unified record, auditing the record for compliance, making use of the records, and developing or revising policies needed to implement the Settlement Agreement. Improvements remain to be made in all provisions.<br><br>The Unified Record contained all required components. Records were in generally good condition, were accessible and secure, included most documents, and were legible. There were no examples of torn pages or missing tabs, tabs were in the correct order, and all pages were readable. Active records contained most required documents, but neither record reviewed in detail by the Monitoring Team included all required documents; data for this small sample of two records was reasonably consistent with the trends data reported by the Facility. Both reviews by the Monitoring Team and audits by the Facility identified a few requirements of Appendix D that were frequently problematic, including gaps in documentation (usually gaps at bottoms of pages of notes or orders, but sometimes gaps in information) and legibility.<br><br>Since the last visit, a competency test was added to the training for new employees.<br><br>The Share Drive provided a means to make records readily available. As with the paper records, many assessments were not posted timely to the Share Drive.<br><br>The Facility had a process in place in which the Unified Records Coordinator and Records Clerks audited five randomly selected records per month. The URC carried out reliability checks through independent audits of the same records audited by the Records Clerks. Interrater reliability was reported only for the monitoring tools, not on the audits of presence of documents; agreement on the monitoring tools was generally acceptable and had improved in September 2012. |

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| | The Facility had a process to notify responsible staff of the need for corrective actions based on audit findings. Review of follow-up emails showed consistent follow-up until each correction was completed. One record checked by the Monitoring Team showed all corrections reported as completed for documents had been corrected, and all but one documentation practice that needed correction had improved and were satisfactory.<br><br>Although the corrective action process included consistent follow-up to ensure corrections were completed, it did not include a tracking process that could provide information on corrections still open across individuals or on the types of deficiencies that had been found. Corrective actions on individual records had not yet resulted in reducing reoccurrence of the same errors, but the Facility had begun systemic corrections to address some issues. The quarterly trend report provided to the Monitoring Team identified three actions and one anticipated outcome to address areas needing improvement.<br><br>Although records were consistently found to be accessible. the Monitoring Team observed that they were not always used in delivering services and supports. Although records were present at meetings, and information from records was frequently referenced, there were also examples in which impressions or interpretations of data were reported rather than data or other information from the records.<br><br>Assessments were frequently not posted 10 days ahead of the meetings; therefore, IDT members could not review the findings and recommendations in preparation for the ISP planning meeting. However, preliminary results of actions taken by the Facility to improve timeliness of assessments were showing improvement.<br><br>Clinicians and QDDPs could describe how they used the records to make decisions and could give examples of doing so. This was the case both for interviews done for monthly audits and for interviews conducted by the Monitoring Team.<br><br>All the above information relates to Provisions V1, V3, and V4, and are related to recordkeeping practices and use of records. Provision V2 relates to policy development and implementation. Both DADS and the Facility had continued to develop and revise policies but not all requirements of the Settlement Agreement have yet been addressed. The Facility needs to develop procedures to ensure staff are informed and understand newly developed and revised policies and that these policies are implemented accurately. |

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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 | <u>Policies Governing Recordkeeping</u><br>Policies governing recordkeeping had not changed since the last compliance report, except for a revision of DSSLC Policy CMGMT-17 Home Shift Log Policy. Although the Home Shift Log is not part of the Unified Record, information from the Home Shift Log could be reviewed for information to that in the Unified Record, according to the Facility. No information was provided about how or how often that occurred, and the Monitoring | Noncompliance |

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| | guidelines in Appendix D. | Team did not review those logs.<br><br>Recordkeeping was to follow DSSLC Policy CMGMT-25 Recordkeeping Practices. This policy operationalized to the Facility the DADS Recordkeeping Practices policy.<br><br><u>Maintenance of a Unified Record for Each Individual</u><br>The Facility maintained a Unified Record for each individual. The unified record at DSSLC consisted of an Active Record, Individual Notebook, and Master Record. There was an individual notebook in the vocational area, also; this contained information for staff along with data sheets that remained for only one month, but the Facility did not consider this to be part of the unified record. In addition, assessments and some other information were copied to a share drive that was not considered part of the unified record but allowed information to be easily accessible to members of the IDT.<br><br>The Active Record was the primary document with information about the individual's current status and about the supports and services being provided. Active Records were filed in two, three, four, or (for some individuals with complex medical conditions) more 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.<br><br>The Individual Notebook contained information needed by people providing daily service. 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.<br><br>Filing was the responsibility of records clerks at each unit. Each unit had two records clerks, and each records clerk was responsible for one to three homes.<br><br>Records were generally well-organized, and it was not difficult to find documents.<br><br><u>New Employee Training</u><br>The URC reported that training is provided in New Employee Orientation (NEO). Since the last visit, a competency test was added to the training. A staff who does not pass is required to retake the class and the test. All staff have passed on the first or second attempt. The plan for someone who did not pass either time would be for the records clerk and URC to go over the same materials with the person one on one and require the | |

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| | | person to retake the test.<br><br>The Facility provided the training handouts for New Employee Orientation. One handout included information, examples of documentation, and practice exercises to complete. The materials addressed the requirements in Appendix D and also provided practice in observing and recording. The Documentation Quiz tested competence in completing an observation note. Samples provided included a passed quiz for one DSP, and a failed quiz and subsequent passed follow-up quiz for another.<br><br>The Facility might consider implementing a process for periodic reviews of documentation by new employees for a period of time; this could be part of the regular oversight process by supervisors with documentation of reviews provided to the URC or other training or quality assurance staff for tracking purposes.<br><br><u>Accuracy and Completeness of Records</u><br>To determine whether Active Records were completed in compliance with Facility policy and Appendix D of the Settlement Agreement, the Monitoring Team reviewed the complete unified record for Individual #273, who had been admitted approximately four months prior to the compliance visit, and Individual #172, who was randomly selected by computer from the list of individuals who had been randomly selected (also by computer, as reported in Provision V3) for record audits to be conducted in October 2012. In addition, audit findings were reviewed for audits conducted during June, July, August, and September 2012.<br><br>In general, the records were neat, and it was usually easy to find documents. There were no examples of torn pages or missing tabs, tabs were in the correct order, and all pages were readable.<br><br>The Monitoring Team checked for the presence of each item on the Active Record Order & Maintenance Guidelines (AROG) and the Individual Notebook. To do this, the Monitoring Team used the same audit forms used by the Facility; these forms listed each document on the left side of the page and "Maintenance Guidelines" (the purging schedule and, for some documents, instructions) on the right side. For each document, there was a box to indicate present, absent, or not applicable. Many documents are not applicable in each record. The Monitoring Team made an effort through review of other documents in the record to determine whether such a 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.<br><br>For Individual #172, the Monitoring Team rated the Active Record as having 80 | |

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| | | documents present, 15 documents not present, and 89 documents not applicable for this individual with the percent or applicable documents present of 84%; for the Individual Notebook, 14 documents were rated present, 0 were rated not present, and 10 were rated not applicable for 100% of rated documents being present. For the Active Record for Individual #273, 66 documents were rated present, 17 not present, and 104 not applicable for 80% of required documents present; for the Individual Notebook, nine documents were rated present, four not present, and 14 not applicable for 69% of required documents present. The percent of required documents present remained similar to the findings of the last compliance visit.<br><br>The Monitoring Team also checked each of these records regarding whether they met all requirements of Appendix D, using the same definitions used by the Facility. In general, most requirements were met. On the monitoring tool for Individual #172, the Monitoring Team found 18 of 25 requirements met (72%); for Individual #273, the Monitoring Team found 19 of 25 requirements met (76%).<br><br>However, each Active Record revealed some requirements not met. Examples are listed below.<br>• Individual #172:<br>o Some consents were not found in the Active Record, specifically the psychotropic medication consent and the consent for the PBSP.<br>o Human Rights Committee review and approval for the PBSP was out of date.<br>o The Integrated Risk Rating Form was not present.<br>o There was no signature sheet for the ISP.<br>o Integrated Support Plan Amendments were not in reverse chronological order.<br>o There were gaps and blank lines in the Observation Notes. The form has a line for each day, but the URC informed the Monitoring Team that empty lines between days should be lined through.<br>o The Mammogram was found between two DEXA scans for bone density.<br>o There were numerous illegible Integrated Progress Notes (IPNs), most apparently from one Medical provider and one nurse.<br>o The September 2012 Medication Administration Record was missing.<br>• Individual #273:<br>o Some items were out of order. Consent for psychotropic medications followed consent for camera surveillance, the ISP Amendment preceded the Integrated Risk Rating Form, and the diet order preceded (rather than followed) the physician's orders.<br>o The Observation Note form had gaps; empty lines between days were not lined through. | |

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| | | o There were gaps at bottoms of pages of physician's orders.<br>o There was no signature legend for physician initials on consultation reports.<br>o Two IPNs were illegible.<br>o The Pre/Active/Post Sedation checklist was in the Dental tab but should have been in the IPN tab.<br>o Not all boxes in the Treatment Record were filled in.<br><br>The data for this small sample of two records was reasonably consistent with the trends data reported by the Facility. That report provided data section by section from the Monitoring Tool. Similar to the findings from this sample, the three components of the Unified Record were found 100% of audits. The other sections had compliance rates from 71% to 88% for the items checked by the Monitoring Team.<br><br>As the Monitoring Team reviewed a large number of records, a few additional errors were noted; however, these were not extensive. For example:<br>• As reported in Provision M1, when errors were made in documentation they were not consistently corrected properly with a straight line drawn through the entry, dated, and initialed, and legibility of the nurses' handwriting had not significantly improved since the last review.<br><br>The Master Record was present for both individuals and appeared neat and in order. The Montioring Team reviewed the Master Record for Individual #273 in detail and found all documents on the Master Record Purging Schedule that would be expected for a recently admitted individual to be present.<br><br>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. This will, however, require that the staff responsible for supervision of documentation take an active role in monitoring and ensuring proper documentation. The Facility Director described a recent process to improve timeliness of completing and posting assessments; this process provides information to the responsible staff but also establishes accountability; such an approach might also lead to improved compliance with required documentation practices.<br><br><u>Accessibility and Security of Records</u><br>All records requested by members of the Monitoring Team were available, indicating that each individual has an accessible Active Record. Observations in homes found both | |

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| | | Active Records and Individual Notebooks to be accessible. The Monitoring Team checked records at three homes, 502D, 511A, and 526D. Active Records were kept in closed cabinets or on a covered rack, and Individual Notebooks were kept in the individual's wheelchair pocket or in a closed cabinet, so these were not visible. They were readily accessible to staff, who were able to show where they were.<br><br><u>Use of Share Drive</u><br>QDDPs demonstrated use of the Share Drive for posting and availability of assessments by PST members. The QDDP identified the required assessments. Per DSSLC policy, assessments are to be posted to the Share Drive 10 days prior to the annual PSP meeting for an individual. The Monitoring Team asked the QDDPs to find assessments for an individual whose ISP annual planning meeting was to be held the week after the compliance visit. A QDDP easily navigated to the correct folder for Individual #578, identified which assessments were posted, and read them. Not all required reports were present, as reported in Provision V3.<br><br>The Share Drive also had other uses. To improve accessibility of information for use by clinicians, many documents that are found in the Active Record are also posted to the Share Drive, including PSPs, PSPAs, and TDRs. This is an excellent tool for making information easily accessible to clinicians and increasing efficiency of their work. | |
| 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. | <u>Facility Process to Develop and Revise Policies</u><br>Per interview with the Quality Assurance Director, there had been no changes in the process for developing policy. Each policy has a primary coordinator who is responsible for the policy and its revisions and secondary coordinator who provides input and assists. The executive management team and other relevant staff provide input. The Facility Director approves policy prior to putting into the policy book and Approved Policies folder on the shared drive. Executive management team members are responsible to train staff on policies. The Facility is planning to establish a Policy Committee that will be the first reviewer of drafts and will track policies to see if there is a need for revisions, as well as track the training required and gather evidence training was completed. The Facility should ensure it provides information on these changes and their effect at the next compliance visit.<br><br>At the time of this visit, the process for determining the training needed was that the policy developer identifies who needs to be trained and provides that list to the Quality Assurance Director. There was not typically a test for knowledge or competency, although review of training on the Recordkeeping Policy indicated that such competency testing did occur for at least some policies. The issue of identifying required training is part of the purpose and role being considered for the planned Policy Committee, according to interview with the Quality Assurance Director. | Noncompliance |

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| | | Departments and administrators were notified of new and revised policies by email and were responsible to update hard copy manuals and to notify staff of changes. The Facility reported that there were no copies of communication to staff to inform them of policy change, and none were provided to the Monitoring Team along with revised policies. The Facility should establish an organized process to communicate policy changes to applicable staff, including providing and documenting training determined to be needed and/or documentation that staff have reviewed the policy.<br><br><u>New and Revised Policies</u><br>DADS policy development, revision, and implementation: DADS had continued developing and revising policies. New and revised policies included the following:<br>• DADS Policy 054 Medical Peer Review 5/30/12<br>• DADS Policy 057 Self-Advocacy 5/30/12<br>• DADS Policy 001.1 Use of Restraint 4/10/12<br><br>DADS issued a substantial revision to its statewide Restraint Policy on 4/10/12. Instructions and training material was provided to each Facility. Facilities were encouraged to phase in implementation of the requirements of the new policy in an orderly manner as staff was trained. Consequently, there was not a firm implementation date from which the Monitoring Team could assess compliance with the new policy. DSSLC revised its restraint policy to meet the requirements of the revised State policy with an effective date of 6/1/12.<br><br>In addition, DADS developed and implemented a new format and process for ISPs. Staff at DSSLC had an initial training, and the first two ISP annual planning meetings using this process were held during the compliance visit. At the time of the compliance visit, this new format and process were supported by draft DADS Policy 004.1 Individual Support Plan Process, which did not yet have a implementation date.<br><br>DSSLC policy development, revision, and implementation: The Facility provided the Monitoring Team with the following policies revised since the last compliance visit:<br>• DADS Policy 001.1 Use of Restraint 4/10/12<br>• DSSLC Policy CM-25 Recordkeeping Practices 2/2/12<br>• DSSLC Policy CMGMT-20 Use of Restraint 6/1/12<br>• DSSLC Policy CMGMT-40 “Advocate” 5/15/12<br>• DSSLC Policy CMGMT-41 Self-Advocacy 5/30/12<br>• DSSLC Policy CMGMT-15 Quality Assurance 9/1/12<br>• DSSLC Policy CMGMT-17 Home Shift Log Policy 6/15/12<br>• DSSLC Policy CMGMT-32 Physical Nutritional Management (PNM) 10/5/12 | |

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| | | • DSSLC Policy DS-12 Dental Services Dental Annual Examination and Summary 9/11/12<br>• DSSLC Policy DS-25 Dental Services Quality Assurance 9/11/12<br>• DSSLC Policy Committees & Councils-05 Pharmacy and Therapeutics Committee 7/5/12<br><br>Following are examples of the changes made to policy in order to progress toward compliance with all requirements of the Settlement Agreement:<br>• DADS issued a substantial revision to its statewide Restraint Policy on 4/10/12. Instructions and training material was provided to each Facility. DSSLC revised its restraint policy to meet the requirements of the revised State policy with an effective date of 6/1/12.<br>• Since the last compliance review, DSSLC had revised a local PNMT policy that defined the roles and responsibilities of the PNMT and the collaboration that was intended to occur with the IDT. The policy was comprehensive and provided clear direction regarding the PNM referral process, implementation of the Physical and Nutritional Management Plan (PNMP), and PNM Quality Assurance components. 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.<br><br>As reported in some sections of this report, there remained a need for some policy development or revision. For example:<br>• As reported in Provision R1, DSSLC had a localized Communication Services Policy (CMGMT-23, rev 11/1/09) that contained many required components but needed revision to include other needed components such as a requirement and process for monitoring of staff compliance with implementation and of effectiveness of services, as well as timelines for completion of assessments for individuals with a change in health status potentially affecting communication.<br>• As reported in Provision H7, the Facility Medical Care policy needs to be updated to reflect revisions to DADS policy, and DADS draft policy on integrated clinical services needs to be finalized and implemented.<br>• As reported in Provision L4, there is a need for revision of policies to guide medical care.<br><br><u>Areas in Which Efforts Are Needed</u><br>The Facility needs to develop and implement an organized process for periodic routine review of current policies to determine any need for revision.<br><br>The Facility needs to establish more formal means to identify what aspects of policies | |

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| | | require training, who needs training, who will provide the training, and who has received training. It would be useful to present findings related to training in terms of the number of staff that have successfully completed the training (n) over the number of staff that require the training (N) to show the percent compliance with completion of the training (n/N). Once policies are trained, the Facility needs to have processes in place to determine whether they are implemented accurately and whether corrective or improvement actions are needed.<br><br>DADS needs to continue to develop and revise policies to ensure all that are needed to implement Part II of the Settlement Agreement are in place. There should be a plan or concerted effort to finalize policies currently in draft form that are actually in process of implementation, including the ISP and restraint policies, as well as to complete others that remain in draft form or have not yet been developed. | |
| V3 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence. | <u>Audit Policy and Process</u><br>The Facility Recordkeeping Policy CMGMT-25 did not reference audits of records, and no other policy or written procedure was provided to the Monitoring Team. The Facility did have 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 Active Record and Individual Notebook. The URC stated she also was to audit four of the five records (to provide an Interrater reliability check) and one additional record; however, review of audits from June through September 2012 found that all audits were conducted by both the records clerk and the URC. Copies of audits done for the months of June 2012 through September 2012 verified that both the records clerks and the URC completed five audits per month.<br><br>Blank record audit forms included on them the definitions or guidelines to be followed in rating presence of documents or compliance with standards. Three tools were used. The monitoring tool was the statewide Settlement Agreement Cross Referenced with ICF-MR Standards form for Section V. The other two forms checked the presence of documents and are described in Provision V1.<br><br><u>Interobserver Agreement/Interrater Reliability</u><br>The URC reported that the record clerk and URC audit a record; recently, an effort was made to do these audits on the same day. For the four months of audits reviewed, 10 of 25 (40%) were dated the same day, five more (20%) were dated one day apart, and five (20%) were dated more than one day apart. For September 2012, four of five (80%) were dated the same day. It is important to do reliability audits close together in time so that no changes are made to the record in the interim, and both auditors review the same documentation. The revised process, which was evident from the September audits, is an | Noncompliance |

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| | | improvement.<br><br>For each audit, the URC compared the findings of the two auditors and calculated the percent of agreement. Trend data provided by the Facility for the months of February through July 2012 reported Interrater agreement on the monitoring tool monthly percentages ranging from 79% to 83% with an overall average of 78%. For the individual audits for September 2012, agreement ranged from 77% to 100% with a mean of 86%.<br><br>Interrater agreement was not reported for the tools indicating presence of documents. This should be calculated and reported also.<br><br>The Monitoring Team also audited the record for Individual #172 at the same time the URC audited it. Agreement on the monitoring tool was 80%, consistent with the interrater reliability scores between records clerks and the URC. This was a significant improvement compared to the findings at the last compliance visit.<br><br>Agreement between the Monitoring Team and the URC on presence or absence of specific documents was not as high, with agreement on the combined Active Record and Individual Notebook of 69%; this was lower than at the last compliance visit. From review of the specific differences and the notes made by both auditors for items not present, it appeared that the URC marked "not present" for items that were present but did not meet all Appendix D requirements (in some cases, this was noted in the guidelines); in fact, for the Individual Notebook, all disagreements involved the URC rating items not present while the Monitoring Team rated them present, which reflected both very careful and conservative review by the URC and the use of Appendix D criteria in making the rating. This is certainly an acceptable practice but should be made clear in a description of the process.<br><br>Overall, the Monitoring Team finds the reliability process, particularly in relation to the monitoring tool, useful to ensure the audits are valid indicators of whether there is a Unified Record that meets Appendix D requirements. To ensure this, the Facility should report agreement between the URC and record clerks on the tool to audit presence of documents.<br><br><u>Audit Findings</u><br>The Monitoring Team reviewed the 20 completed audits for June through September 2012, reviewing the monitoring tool and the tools to report presence of documents. All monitoring tools reported that the three components of the Unified Record—the Active Record, Individual Notebook, and Master Record—existed. For the whole monitoring tool, the ratings by the URC reported compliance with from 78% (one record) to 100% | |

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| | | (one record). The audits did not report percent of documents present; that information was used only for identifying the need for corrections to be made and to provide information for completion of the monitoring tool.<br><br>For the audit conducted to determine agreement between the Monitoring Team and URC, the percent compliance on the monitoring tool was rated by the Monitoring Team as 72% and by the URC as 69%; both of these are lower than any in the range reported for June through September 2012. The Monitoring Team found compliance at 76% for the other record audited during this visit. These records might have been outliers, or there could be question about the accuracy of prior audits. The Facility will need to review the remainder of October and future audits to determine whether monitoring shows records to be more accurate as audits had found in prior months.<br><br>Audits reported certain issues had been found routinely. For example:<br>• Gaps in documentation occurred frequently in several sections. These were usually blank spaces at the bottom of pages or in between entries, without a line through them. Some were gaps in documentation, but this was not frequent.<br>• Legibility was a problem, especially regarding signatures.<br><br><u>Corrective Actions</u><br>As reported by the URC and verified by review of audits, the process of correction began following the audit with the URC sending an email of the findings and corrective actions needed to the people responsible for the specific documents or to administrative staff responsible for actions requiring training or systemic improvements (such as improving legibility, which cannot be corrected on the document itself but should be improved on current and future documentation). A due date for responses of five business days was stated in the emails.<br><br>The Facility reported that the next step in the process was for the URC to track findings sent for correction between five and 10 days after sending the deficiency list. At that time, the URC went to the apartment to check each required correction and determine whether it was "cleared." If not yet corrected, the URC sent the email again describing what is needed and returned the next day to check the record. When that was not successful, she spoke to the Unit Director, Director of Residential Services, or other appropriate department director.<br><br>The URC documented status of corrections by writing on a hard copy of the email that the correction was done, not done, forwarded to a supervisor or administrator for action, or other action. No tracking system was in place for corrective actions other than review of the email copy with comments. A tracking system that also categorized the types of errors needing correction could also help identify areas for systemic improvement | |

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| | | initiatives that could lead to the audit system becoming more effective in reducing reoccurrence of deficiencies and greater compliance and usefulness of records.<br><br>The Monitoring Team reviewed corrective action emails for one audit done each month from June 2012 through September 2012 (Individuals #123, #383, #608, and #628. The Monitoring Team spot-checked specific documents found not present as well as all criteria reported on the monitoring tool as "N" to see whether there were matching corrective actions listed on the emails. Nearly all required corrections were listed, with one omission.<br>• For Individual #123, the monitoring tool had "N" for having an initial legend, but no correction was listed in the email.<br><br>Review of the follow-up emails showed consistent follow-up until each correction was completed. Evidence of completion did, in some cases, include training sheets, but this was not consistently done even when the audit findings indicated that several staff were making a similar error (e.g., illegible signatures, gaps in documentation).<br><br>The Facility provided a number of Document Tracking forms as evidence of a practice now being required for checking documentation on every shift every day. The instructions require checking that signatures and initials are legible. This would be a systemic response to issues that were commonly found in the audits. These were provided on the last day of the compliance visit, and no information was provided regarding how long this process has been in place, whether it is in place across the Facility or at specific apartments or units, whether this was a probe for one week or this is an ongoing process, or any other instructions. This could be an effective approach and does show an effort to make the staff responsible for documentation accountable to check and correct errors. The Monitoring Team looks forward to reviewing this process and its effects at the next compliance visit.<br><br>The Monitoring Team selected randomly by computer from audits done in August the record for Individual #633 to check for whether corrections reported completed had been done, and went to review the record at the individual's apartment, accompanied by the URC. The Monitoring Team found that all cleared corrections but one had actually been completed; the record continued to miss signatures for observation notes in the Individual Notebook. All items that could be corrected had been (such as purging outdated documents and filing missing observation notes in the record), and several practices were now being done correctly (for example, gaps in documentation were no longer occurring).<br><br><u>Review of Trends and Use of Audit Information for Improvement</u><br>The Facility reviewed findings of the audits at the QA/QI Council meetings. Trend data | |

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| | | were reported from the Settlement Agreement Cross Referenced with ICF-MR Standards tool and were presented in bar graphs for quarterly averages for each provision and line graphs for overall compliance with each provision each month. These graphs showed levels of compliance on the monitoring tool generally above 80% but with some areas of improvement needed.<br><br>The quarterly report provided to the Monitoring Team identified three actions and one anticipated outcome to address areas needing improvement. The actions were:<br>• The 10/6 (daytime) building coordinator will review "a list of injuries, illnesses, ATV and appointments for the past week" each Friday, will check the record to ensure documentation is present, and will "turn into [sic] the Unit Director for corrections." This appears to be the information found in the Document Tracking form mentioned above. The expected outcome is to identify and address underreporting.<br>• The 10/6 building coordinator will, on Fridays, have staff review the individual notebooks and skill acquisition plans for gaps, signatures, and legibility of signatures, and will address missing information.<br>• An action plan was to be submitted for Provision V4 in two weeks.<br><br>The Facility reported another initiative related to the Unified Record. To address problems with completion and filing (or posting on the Share drive) of assessments, the Facility had begun to send a notice to all clinicians and department heads identifying assessments that were not posted 10 days prior to the annual ISP planning meeting, along with taking other steps to address quality of assessments. September data showed increases in timely completion and posting of assessments for nearly every discipline. The Monitoring Team will review the effect and any additional actions taken to improve timeliness of assessments and entry into the record at the next compliance visit but commends the Facility for taking steps to address the issue.<br><br><u>Additional Audits</u><br>A new process was started in which an ISP Integrated Monitoring Tool is used for observations of ISP meetings. The Director of Quality Assurance informed the Monitoring team that this tool was implemented in September, and nine observations had been done by the time of the compliance visit. The first half of the tool is to be used at the ISP planning meeting, with the remainder to be used two months later to complete a document audit to determine if everything planned at the meeting was incorporated into the actual document; that had not yet begun. No items specifically addressed presence or use of the records, although several items indirectly assessed use of the records or reports of information from the records, such as:<br>• "Refer to the Nursing assessment. Did the IDT discuss address [sic] the | |

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| | | recommendations?" (Note the same referral and question were included for Medical, vocational/Life Skills, Dietary/Nutritional, Dental, Pharmacy, Recreation/Water Safety, OT/PT, and Personal Focus assessments).<br>• "Did the IDT review the PNMP and whether it was accepted (remained appropriate) or revised?"<br>• "Did the IDT discuss individualized triggers, thresholds and revisions to trigger data sheet?"<br><br>At the next compliance visit, the Monitoring Team will review any information provided by the Facility to indicate how this process has affected completeness, accuracy, or use of the unified record.<br><br><u>Summary</u><br>The Facility audited five records per month. The audit process was comprehensive, reliability was generally adequate (although there remains a need to report reliability on the tool to check presence of documents), and a corrective action process was in place. Although the corrective action process included consistent follow-up to ensure corrections were completed, it did not include a tracking process that could provide information on corrections still open across individuals or on the types of deficiencies that had been found. Corrective actions on individual records had not yet resulted in reducing reoccurrence of the same errors, but the Facility had begun systemic corrections to address some issues. To achieve compliance, the Facility will need to show that audits and any additional quality assurance procedures reduce reoccurrence of errors. | |
| 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 Monitors and the parties agreed to a list of actions that the facilities would engage in to demonstrate substantial compliance with this provision item. These actions are categorized below, with report of their status at DSSLC.<br><br><u>Records are accessible to staff, clinicians, and others</u><br>The Facility was assessing this through the record audits. Audits of 20 records from June through September 2012 and the audit conducted by the Monitoring Team found the record to be accessible in all 21 audits (100%). During observations by the Monitoring Team, Individual Notebooks were found in the area in which individuals were, including living areas and day program sites. Active Records were kept in a cabinet or covered shelf to which staff had access.<br><br>The S: Drive made assessments readily available to clinical staff, residential directors, QDDPs, and others who might need to refer to them. | Noncompliance |

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| | | However, the Monitoring Team observed that although records were accessible, they were not always used in delivering services and supports. For example:<br>• As reported in Provision V1, not all required documents were found in the record.<br>• As reported in Provision O4, although PNMPs were provided at various locations, at no time during any of the observations was staff observed referring to the PNMPs.<br><br>One positive example of documentation to assist DSPs to deliver services is that acute care plans (ACPs) 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 DSPs were more individualized to meet individuals' health care needs they were responsible for carrying out. The special instructions were written at a level that could be easily understood by the DSPs.<br><br><u>Documents are filed in the record timely and accurately</u><br>The monitoring tool for record audits checked whether documents in the record were current. Responses to that item on the reviewed audits showed five of 21 (24%) to be rated as current.<br><br>Other than the record audits, the focus of assessment of timeliness was on the presence of assessments 10 days prior to the annual ISP planning meeting. As described above in Provision V3, the Facility was tracking timely completion and entry into the record regularly, had graphed monthly data on timeliness, and was addressing the issue. At the time of this compliance visit, however, assessments were frequently not posted 10 days ahead of the meetings; therefore, IDT members could not review the findings and recommendations in preparation for the ISP planning meeting (although, as reported in Provision F1c, there had been recent improvement). The Shared drive folder for Individual #578 was opened to determine the status of assessments due in preparation for the individual's upcoming ISP annual planning meeting. The Facility did not yet have a checklist of the assessments that would be required for this individual; development of such a list is a requirement of the new ISP process that was being put into place. Of 16 assessments listed, 15 (94%) were completed, and 11 (69%) had been completed 10 days prior to the ISP meeting date.<br><br>One process that enabled information to be available timely was implemented by the Hospital Liaison Nurses. After visits to the hospital, the Hospital Liaison Nurses reported and scanned all medical information into the hospital reports folder and into each individual's folder, in order to make it available to medical providers, nursing staff, and | |

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| | | other relevant Interdisciplinary Team (IDT) members.<br><br><u>Staff surveyed/interviewed indicate how the unified record is used</u><br>To assess this item, the Facility reported in the Self-assessment that it conducted interviews using the Interview Tool for use of the Record. In addition, it used an item on the record audit to determine whether the record itself showed used of the record, based on whether at least five disciplines made IPN entries during the prior six months.<br><br>The self-assessment reported that results from three of three (100%) of the Interview Tool for the use of the Record from June, July, and August 2012 showed 81% compliance. The Monitoring Team reviewed these three interview forms. The number of disciplines responding was either two or three. The Facility also provided the Interview Tool for September, for which there were two responses. Review by the Monitoring Team indicated agreement that all interview forms showed use of the record, with the possible exception of one response from September which was too general in nature and did not give information that clearly showed use of the record (and for which it would have been advisable to ask follow-up questions to get more specific information).<br><br>The Monitoring Team used the same questions to interview the QDDP Coordinator and one lead QDDP, and the directors of medical, psychiatry, and behavioral services about use of the record. The lead QDDP stated that most of the time, instead of reviewing the record itself, she reviewed specific documents before they were filed, such as consultations and assessments. Then she described reviewing progress notes when doing monthly reviews, and she described a specific situation in which a QDDP she supervises reviewed several specific documents for an individual, which led to a decision on more intensive monitoring and observations. She stated that the record is brought to meetings and reviewed for specific information as needed, but that IDT members bring information from the record to meetings so they don't have to open the records to search for information frequently. She also described the usefulness of the shift logs, which are not part of the Unified Record but provide a broader perspective because they provide information about the whole apartment.<br><br>The Director of Medical Services and Director of Behavioral Services were able to provide specific examples of use of the records at an ISP meeting and at an Ethics Committee meeting, during round, and at the Positive Behavior Support Committee reviews of behavioral programs. Both indicated that records are not always filed timely or may be purged when still needed, and both stated the Share drive makes documents more readily accessible. The Lead Psychiatrist stated the record is used on an ongoing basis and available and used at all scheduled meetings. She provided an example of an individual for whom the record of a medical consultation was used in making a decision | |

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| | | about psychotropic medication.<br><br><u>Observation at meetings, including ISP meetings, indicates the unified record is used and data are reported rather than only clinical impressions</u><br>The Monitoring Team observed the annual ISP Planning meeting for Individual #250. The Active Record was present. Many IDT members had with them information that was either directly from the record (e.g., assessments) or was summarized from information in the record. In some cases, specific information or data were provided, such as weight, medications, and number of times treated for ear infections (all reported on the IRRF draft). In other cases, data that might have been useful for the IDT were summarized instead; for example, interpretation of the behavioral data was provided, but the data themselves were not in either the discussion or on the IRRF draft. As there was discussion of the possible relationship of problem behaviors to requests for snacks, it would have been useful for data to be provided so that objective information would have been available for decision-making. There was also extensive discussion of the individual's preference not to work, along with discussion of all the other activities the individual participates in, but there were no data provided on actual attendance at work or on participation or productivity when at work. | |

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

1. Consider implementing a process for periodic reviews of documentation by new employees for a period of time; this could be part of the regular oversight process by supervisors with documentation of reviews provided to the URC or other training or quality assurance staff for tracking purposes. (Provision V1)
2. In order to have a larger pool of audits as a means to increase accountability for documentation and data on trends that can help identify areas for improvement initiatives, consider selecting a larger number of records to be audited for each unit (at a minimum, one per records clerk monthly), while continuing to have the URC do reliability audits on five of those randomly selected records monthly. (Provision V3)
3. Implement a tracking system for corrective actions from record audits that allows a review of all corrective actions required and those that remain open. (Provision V3)
4. Establish an organized process to communicate policy changes to applicable staff, including providing and documenting training and/or documenting that staff have reviewed the policy. As part of this process, 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. (Provision V2)
5. Develop and implement an organized process for periodic routine review of current policies to determine any need for revision. (Provision V2)

# List of Acronyms
# Denton State Supported Living Center
# October 8-12, 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, Action Plan |
| 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 |
| BMD | Bone Mineral Density |
| 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 |

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| CME | Continuing Medical Education |
| CMS | Centers for Medicare and Medicaid Services |
| CEU | Continuing Education Unit |
| CNE | Chief Nurse Executive |
| COP | ICF/MR Condition of Participation |
| CPE | Comprehensive Psychiatric Evaluation |
| 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/DSP | Direct Care Professional/Direct Support 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 | Direct Support Professional, 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 |

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| 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 |
| MVC | Medication Variance Committee |
| NA | Not Applicable |
| NANDA | North American Nursing Diagnosis Association |
| NCP | Nursing Care Plan |
| NDC | Non Direct Care/No Direct Contact |

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| 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 |
| PDD | Pervasive Developmental Disorder |
| 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 |

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| 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 |
| RAD | Reactive Attachment Disorder |
| 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 |
| SAP | Skill Acquisition Plan |
| 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 |

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| 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 |